Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 3 Physician/ 10:00 P M 2012 Julius Samuel Piver Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery 6602 Melody Lane Rethesda 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign) **Funeral** Hours Min. (Month, Day, Year) 579-20-8698 Washington, 1 X M 2 D F Director 87 4-30-1924 Usual Residence of Decedent show 10d. Inside City Limits ms 23a or 28a-f sho must be notified at 10c. City, Town or Location Director Y Yes 2 No MD Bethesda Montgomery 10f, Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 20817 United States 6602 Melody Lane item 27 is marked other than "natural", or items other traumatic event, the Medical Examiner mu Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S 11. Marital Status Armed Forces?

1 X Yes 2 If Yes, Give Black, White, etc. Completed by 2 No WWII 1 Never Married 2X Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify: Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Medical Physician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Sonia Bard Harry Piver 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 6602 Melody Lane, Bethesda, Maryland 20817 Louise Rubin Piver - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any injury or o 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3-27-2012 | Falls CHurch, Virginia Mational Cremetory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Danzansky-Goldberg Jamie Arthurs 1170 Rockville Pike, Rockville, Maryland 20852 M01163 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition resulting in death) Bladder Cancer Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or injury the bunial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE: nse s 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 5 Other (specify) ate has been signed by the a page 2 should be detached Unknown • Hospital or Attending Physician: The law requires that the 24 hours after death.
• Funeral Director. After this certificate has been signed by the thing of the control of the co Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \square Nursing Home X Residence 6 \square Other (Specify) 1 🗌 Yes 2 XNo ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1X Natural injury 5 Pending work?
1 \(\sum \) Yes 2 \(\sum \) No ☐ Accident Investigation filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical

To the I within 2 To the I

Manish Agrawal, MD 9707 Medical Center Drive #300 Rockville MD 20850 31. Date filed (Month, Day, Year) APR 02 2012 Registrar

3 [

29b. Signature and title of certifier

29a. Certifier

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D62234

29d. Date signed (Month, Day, Year)

3/23/12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year LAPRY BAILEY LEE PORTER Physician/ 05.50AM 2012 Medical 4c. County of Death Harford Co 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Bel Air Upper Chesapeake Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Davs Hours (Month, Day, Year) 216-19-9760 Director 1 DM 2 - F 10/15/1991 Maryland 20 Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10b. County within 72 hours after death with the Maryland notified at Director 1 Yes 2 No Edgewood Baltimore Co. MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe ö must be Funeral items 23a U.S.A. 21040 508 Pintail Ct. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status the Medical Examiner Armed Forces?

1 Yes 2 No 9 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", Completed 3 Widowed 4 Divorced Black Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) unemployed traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental h permit. Page 1 and 2 should be fil.
Department of Health and Mental
Important: If item 27 is marked of
any injury or other traumatic eve 2 Charlene Porter Larry B. Baylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 508 Pintail Ct., Edgewood, MD 21040 John Howard(Brother) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03/29/12 Baltimore, MD King Memorial 21. Sig turn of Funeral Service Licenses Funeral Home PA 22JosephdreHof Fabrown Jr. acqueline MD 21217 Baltimore, 2140 N. FUlton Ave., 23d. Part 1. Ent the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ End Due to (or as a con Squence of): Rhabdomyssascoma disease or condition Medical resulting in death) Examiner Sequentially list conditions Examiner Due to or as a consequence of cause. Enter Underlying attending physician and for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Forter Land m80 Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completely filled in by the funeral director, page 2 should be detached it Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No Hospital or Attending Physician: The 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital ၣ _2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Medical Certificate: 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No injury 1 X Natural 5 Pending Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 the only one) 29b. Signature and title of cert 29c. License number 29d. Date signed (Month, Day, Year) 0 D0068014 03/25/2012 en 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) hesapeake Dr Bel Air, MD 21014 Hug 31. Date filed (Month, Day, Year) 32. Registrar's Si

Registrar

APR 0 2 2012

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760 43 To the Hospital or Attending Physician: The law requires that the death certificate be

n/	Registrar 1. Decedent's Name (First, Middle,	,		rtificate of L		2. Date of D	Reg. No.	Year	3. Time of De					
al	The state of the s		3. Peete				Mar 24, 201	12	154					
er	4a. Facility Name (if not institution, Lorien Nursing 8			4b. City, Town, or	Columbia		4c. Coun	nty of Death	ward					
			ge (In yrs. last birthday)	If Under 1 Year	If Under 24 Hr	rs. 8. Date of B		9. Birth	place (State or Fo					
	216-28-3637 Usual Residence of Decedent	1 □ M 2 🕇 F	89 Yrs.	Months Days	Hours Mir	, ′	g 1, 1922	Coun	Теха					
Director		Howard	10c. City, Town or Lo		Columbi	a			1 X Yes 2					
	10e. Street and Number 6726 Quiet Hours			10f. Zip Code	21045		10g. Citizen o	of What Cour	,					
ed by Funeral	11. Marital Status 1 Never Married 2 Marr 3 X Widowed 4 Divorced	12. Was Decedent Armed Forces 1 Yes 2 If Yes, Give Year or Dates.	?	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🗷 No	ispanic Origin? (n, Mexican, Pue			ace - Americ lack, White,	can Indian, etc.					
Completed	(Specify only higher	t's Education st grade completed) College (1-4 or	(Give	edent's Usual Occup e kind of work done o DO NOT use retired) Nursing		-	16b. Kind of	Business/In						
Be	12. Father's Name (First, Middle, Lo	ast)		Hulomi		ame (First, Middle	e, Maiden Surnai		, icai					
은		William Jo	nes				Elvira Lev	wis						
	19a. Informant's Name/Relationsh			ing Address (Street a		Rural Route Numb	al Route Number, City or Town, State, Zip Code)							
	20a. Method of Disposition		20b. Place of Disp	20b. Place of Disposition (Name of cemetery, crematory or other place)				20c. Location - City or Town, State						
	1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)			Ridge Cemeter		ar 31, 2012	Pik	esville,	Maryland					
al Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or a:	s a consequence of): s a consequence of): s a consequence of):											
gi	IF FEMALE: 23b. Was decedent pregnant in the past 12 gronths? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 23d. Date 23d. Date								ery Day Yeal					
hysician/Medica	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant	1			Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contributions to the property of								
Physi	23b. Was decedent pregnant in the past 12 gronths? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant 9 ☐ Unknowr		underlying cause giv	ven in Part I.	1 C 24a. Wa aut per	s an 24b opsy formed?	o. Were auto prior to co death?	bably 4 Unl					
Physi	23b. Was decedent pregnant in the past 12 gronths? 1	4 Pregnant 9 Unknown		cocial 26. Pl	ace of Death (Ch	1 ☐ 24a, Wa aut per 1 ☐ Yes	s an 24b opsy formed?	o. Were auto	bably 4 Unl					
To Be Completed by Physi	23b. Was decedent pregnant in the past 12 gronths? 1	4 ☐ Pregnant 9 ☐ Unknown ns contributing to death Cot Column Hospital: 1 ☐ Inpa	but not resulting in the	26. Pi	ace of Death (Ch	24a, Wa aut per per per la	s an 24b opsy formed? No	o. Were autoprior to codeath? 1 Yes	bably 4 ☐ Unl psy findings avai mpletion of caus 2 ☐ No					
To Be Completed by Physi	23b. Was decedent pregnant in the past 12 gronths? 1	4 Pregnant 9 Unknown ns contributing to death Pospital: 1 Inpa 28a. Date of in (Month, D ation 18a. Place of Ir	but not resulting in the	26. Pl. ent 3 □ DOA Othe of 28c. Injun work M 1 □	ace of Death (Ch	24a. Wa aut. per 1 \subseteq Yes eeck only one) Home 5 \subseteq Res 28d. Describe	s an oppsy formed? S 2 No Sidence 6 Other how injury occur	b. Were autoprior to co death? 1 Yes ther (Specify arred	bably 4 \square Unipsy findings avaimpletion of caus					
Certificate: To Be Completed by Physi	23b. Was decedent pregnant in the past 12 pronths? 1	4 Pregnant 9 Unknown ns contributing to death 1 Inpa 28a. Date of in (Month, D ation not be ned 28e. Place of Ir building, e	titient 2 ER/Outpatie jury al, Year) ER/Outpatie injury - At home, farm, st	26. Plent 3 □ DOA Other work M 1 □ reet, factory, office	ace of Death (Char: 4 Nursing y at ? Yes 2 \(\square\$ No	24a. Wa aut 1	s an oppy formed? s 2 No sidence 6 0 Ot how injury occu	b. Were autoprior to co death? 1 Yes ther (Specify arred	psy findings avaimpletion of caus 2 \(\sum \) No					
To Be Completed by Physi	23b. Was decedent pregnant in the past 12 pronths? 1	4 Pregnant 9 Unknown ns contributing to death Correct Hospital: 1 Inpa 28a. Date of in (Month, D ation not be 28e. Place of Ir	but not resulting in the	26. Plant 3 DOA Other of 28c. Injury work 1 Creet, factory, office occurred at the time stigation, in my opinice, death occurred at t	ace of Death (Char: 4 Nursing vat? Yes 2 No	24a. Wa autu per 1 Pyes neck only one) Home 5 Res 28d. Describe 28f. Location City or 7c	s an oppsy formed? s 2 No sidence 6 On how injury occur (Street and Number, State) cause(s) and main and place, and cothe cause(s) and main the cause(s) and cothe c	ther (Specify arred as stated to the call of manner as stated of manner as stated as s	psy findings avairmpletion of caus 2 No Route Number, ed. use(s) and mannestated.					
edical Certificate; To Be Completed by Physi	23b. Was decedent pregnant in the past 12 pronths? 1	Hospital: 1 Inpa 28a. Date of in (Month, D ation not be ned 28e. Place of Ir building, e	but not resulting in the	26. Placent 3 DOA Other work M 1 DOA Treet, factory, office	ace of Death (Char: 4 Nursing vat? Yes 2 No	24a. Wa autu per 1 Pyes neck only one) Home 5 Res 28d. Describe 28f. Location City or 7c	s an oppsy formed? s 2 No Sidence 6 Other open open open open open open open open	ther (Specify arred as stated to the call of manner as stated of manner as stated as s	psy findings avairmpletion of caus 2 No Route Number, ed. use(s) and mannestated.					

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Mark Shane Plaisance State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Reg. No. Physician/ Decedent's Name (First_Middle Last) 2 Date of Death Medical Examiner Shane Plaisance 0844 hrs March 25, 2012 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1934 Inverton Road Dundalk **Baltimore County Funeral** 5. Social Security Number 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Director 436-02-9603 Months Days 1X M 2 F 44 Apr 26, 1967 oursiana Usual Residence of Decedent 10a. State 10c. City. Town or Location 10d. Inside City Limits Md. Baltimore Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho
injury or other traumatie event, the Medical Examiner must be notified at once. Dundalk 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1934 Inverton Road 21222 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 1 Never Married 2 X Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Yes White etc 3 Widowed 4 Divorced If Yes, Give Year 2 1 Yes 2 X No specify: Specify: White or Dates 15. Decedent's Education (Specify only highest grade completed) Completed 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12th vrs Senior Computer Operator|United Health Care 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Llovd Plaisance Adeline Benoit 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michele Plaisance - Wife 1934 Inverton Road Dundalk, Maryland21222 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, March 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify Bayview Crematory 31,2012 | Baltimore, Maryland 21. Signature of Funeral Service Licensee 22 Name and Address of Facilit Kaczorowski Funeral Home, PA 1201 Dundalk Avenue Baltimore, Md.21222 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interval /Medical Between Onset and a Pontine Hemorrhage Examiner Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): ы Hypertensive Atherosclerotic Cardiovascular Disease Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): requires that the death certificate be executed and Physician/Medical the attending physician ₩ UNPENDED AMENDED 23a-b, 27, per me, g927 5-2-12 sm Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth past 12 months? 2 Fetal death Month Day Year Pregnant at time of death 5 1 Yes 2 No 9 Unknown Other (Specify) Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ö 23e. Did tobacco use contribute to the cause of death? É ۵. Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown has been si 24a. Was an 24b. Were autopsy findings available To the Hospital or Attending Physician: The law r within 24 hours after death. To the Funeral Director: After this certificate has b autopsy prior to completion of cause of performed? ✓ Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26 Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 🗸 Other: Scene After this 1 Yes 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending ector: by the i 1 Yes 2 No 2 Accident Investigation filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 Could not be 28f. Location (Street and Number or Rural Route Number, City Suicide determined Homicide (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. March 26, 2012 30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year) State 32. Registrar's Signature Registrar Barko DHMH 17 Rev 1/2001

OCME 2006

12-02399

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 2012^{Year} Physician/ 11:36 PM 27 Kyung Ja Park Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore 113 Hollow Brook Road Timonium Birthplace (State or Foreign Country) Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 124-52-7074 Hours Min (Month, Day, Year) **Director** 1 🗆 M 2 💢 F Mar. 20, 1939 73 South Korea Usual Residence of Decedent 28a-f shov 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits Director 1 🗆 Yes 2 🔀 No Timonium . MDBaltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21093 113 Hollow Brook Road USA 72 hours after death 12. Was Decedent Ever in U.S. Was Deceded.
Armed Forces?
Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed Specify: 3 Widowed 4 Divorced Korean 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Self Employed Cleaning/Tailoring permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Chung Soon Tae Yoon Jung 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1733 Oakdale Drive; Cooksville, MD 21723 Chin Kwon daughter Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 4 Donation 5 Other (Specify) Marriottsville, MD Crest Lawn Memorial 3-31-2012 21. Signature of Fundamental Service Li 1050 York Road 22. Name and Address of Facility once. Ruck Towson Funeral Home, Inc. Towson, MD 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. rvall Between settand Death Immediate Cause (Final Physician/ metastat disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Due to for as a consequence of, cause. Enter Underlying Exami Cause (Disease or injury that initiated events resulting in death) Last tran Due to (or as a consequence of) burialattending physician I for use as the buria /Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death signed by the a Part I, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ipheral neuropathi Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform this certificate 2 🗆 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 1 Tes ပ 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) After this funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of eath 28b. Time of 28c. Injury at work? Certificate: Describe how injury occurred 1 Natural 5 Pending thin 24 hours after death.

the Funeral Director: Af
mpletely filled in by the fu 1 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2

To the I

complete Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signat Name and address of person who completed cause of death (Hong 23a) (Type, Print)
Sichard Litherville, MD 21 Richard L. Huslig MD 32. Registrar's Sig State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year March Phyllis Preston Pusey 201 07 Medical 4a. Facility Name (if not institution, give street and number, 4b. City Town or Location of Death 4c. County of Death Examiner Harford itizens Home D NUTSING VIE 0 Grace 7. Age (In yrs. last birthdav If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 M 2 F Months Hours Min Mary Land 14074747918 93 Director 213-18-0951 Usual Residence of Deceden show "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 512 Richards Lane 21001 USA 72 hours after death . Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ ☐ Yes 🏋 No Maryland 21215-0036 1 Yes 2 No Specify: white If Yes, Give 3 Widowed 4 ☐ Divorced Completed Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 housewife in home Be Page 1 and 2 should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Benjamin Burdell Preston Beulah Welsh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 is Health Joel B. Pusey (son) 512 Richards Lane, Aberdeen, Maryland 21001 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date ō 0 1 Denial 2 Cremation 3 Removal from State injury o 4 Donation 5 Other (Specify) Aberdeen, Maryland 3/28/2012 Presbyterian Signature of Funeral Service Litenses 22. Name and Address of Facility Maryland 21001 Funeral Home, P.A. Aberdeen, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that the death certificate be executed and the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Box 68760 as t IE EEMALE for use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) 2 No the 9 Unknown 9 Unknown Divise y Phyllis Division of Vital Records, P.O. completed filled in by the funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown 2 No 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ပ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, Homicide within 24 hours after To the Funeral Dire City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated the only one 29b. Signature and the of certifie

Registrar

State

30. Name and address of person who completed

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1:15P M Physician/ Month 3 Year Chand 2012 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MERIDENE BAUTIMORE Birthplace (State or Foreign Country) 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral Director** 1 M 2 🗆 F MD 82 10c. City, Town or Location 10d. Inside City Limits Director r 28a-f sl notified BATIMORE MD 1 Yes 2 ☐ No 10e. Street and Numbe 0 10g. Citizen of What Country? must be 23a Funeral 1336 MERIDENE 21239 USA 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. 0 Completed by 1 X Never Married 2 Married 1 ☐ Yes 2 No Specify. "natural". Specify: WHITE 3 Widowed 4 Divorced Year or Dates 27 is marked other than "nature traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) PRIVATE CONTRACTOR Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. ELECTRICIAN Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) UNK 18. Mother's Name (First, Middle, Maiden Surname) ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MELISSA CORDOVA CAREGIVER t of Health 1336 MERIDENE DR. BAUTO, MD. 21239 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p Important: If it any injury or o once, ☐ Burial 2 Cremation 3 ☐ Removal from State BACTIMORE, MD 4 Donation 5 Other (Specify) GREENE FUNERAL SCUS 21. Signature of Funeral Service Licenses VAUGHN 1504 RIAO. hter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) neo Ilitus Physician icheta Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) or Attending Physician; The law requires that the death certificate be executed Cause Disease or injury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
Pregnant at time of death 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy this certificate 2 No Yes 2 🔀 1 Yes funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at Director: After (Month, Day, Year) 1 Natural 2 Accident 5 Pending work' Μ 1 Yes 2 No Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined within 24 hours a To the Funeral C Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 U Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number (000404 30. Name and address of person who completed gause of death (item 23a) (Type, Print) Baltimore Bidma 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 03 2017 Rauck 03:29 a^M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Baltimore 7804 Oak Avenue 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Dec. 11, Year) 934 1 □ M 2 🕅 F Months Days Hours Min. Mary land Director <u> 212-32-6665</u> Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c, City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2 X No Baltimore Baltimore Maryland 10e. Street and Number 10f. Zip Code ō 10g, Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or amy njury or other traumatic event, the Medical Examiner must be rone. Funeral U.S.A. 21234 7804 Oak Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 X Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Entertainment Elementary/Seconday (0-12) College (1-4 or 5+) Industry Country Western Singer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bollinger Charles Raymond Addison, Sr. Ruth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, Maryland 7804 Oak Avenue Sheri Rauck Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ☐ Burial 2 X Cremation 3 ☐ Removal from State Donation 5 Other (Specify) Hilltop Service Corp. 4-2-2012 Towson, Maryland 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signiture ceLicensee 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph sician ame disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed ause (Disease of imjury signed by the attending physician and dbe detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy Live Birth 2 Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Day Year Pregnant at time of death 1 Yes 2 9 Unknown page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performe 1 ☐ Yes 2 ☐ No 2 2 No the nosponse within 24 hours after death.

To the Funerall Director After this certified in by the funeral director, the funeral director director, the funeral director director, the funeral director direc 25. Was case referred to edical Be 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yeş 2 M No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 27. Manne of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending work's ☐ Accident 1 Yes 2 No Investigation 6 Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 7/2009

APR 0 2 2012

31. Date filed (Month, Day, Year)

0. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Himan

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 5:30 PM GRACE 3012 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner HOWA 174 BALLARD WAY ICOTT 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Security Number **Funeral** 1 □ M 2 🔐 F Months Days Hours Min. 98-28-242 Director 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or from many injury or other trainment. 10b. County 10c. City, Town or Location 10a. State **Funeral Director** 1 🗌 Yes 2 📉 No V D HOWA LLICOTT 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 09 5, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: 3 ₩ Widowed 4 □ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry College (1-4 or 5+) Elementary/Seconday (0-12) NURSE MEDICAL Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ MANIERI ROSE MARIE ANTHONY MONACO 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2309 ABIGAIL BALLARD WAY ELLICOTT 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4/2 4 ☐ Donation 5 ☐ Other (Specify) ARDENT HAN OUER. CREMATION 22. Name and Address of Facility JUSEPH MARZULLO FUNERAL CHAPEL moce 78 6009 ROAD HARFORD Pay 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ aprtic Years ease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Fctonic pregnancy in the past 12 months?
1 Yes 2 No Month 5 Other (specify) Pregnant at time of death been signed by the should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No has 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical filled in by the funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Tyes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 🗌 Yes 2 🗌 No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred iniury 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

DHMH 17 Rev 7/2009

29b. Signature and life of certifier

31. Date filed (Me

Scare

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Sign

10700

29c. License number

0-53636

Charter Drin

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Rea. No Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 10250AM Marc Rosa G. Sancho-Davila Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Washington Medical Center Glen Burnie Anne Arundel 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** Hours Min (Month, Day, Year) Country) **Director** 218-06-0333 1 □ M 2 💢 F 97 30, 1914 Peru Usual Residence of Dece ms 23a or 28a-f show must be notified at 10c. City, Town or Location 10a. State 10b. County 10d, Inside City Limits Director 1 Yes 2 X No Severn MD Anne Arundel 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 7859 Bastille Place 21144 death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or iter edical Examiner n 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian. Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 X Yes 2 ☐ No Specify: 3 X Widowed 4 Divorced Completed Latino Black event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) th and Mental Hygiene.
77 is marked other than traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Department of Health and Ment Important: If item 27 is markany injury or any injury or Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rebeca Williams / Daughter 7859 Bastille Place Severn, Maryland 21144 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c, Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arundel Crematory 3-20-2012 Odenton, Maryland 21. Signature of Juneral Service Lice Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road Odenton, Maryland 21113 Part 1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arres shock, wheart failure. List only one cause on each line. disease Immediate Cause (Final Onset and Death Ph. sician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year signed by the at Id be detached for P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy filled in by the funeral director, page 2 s after death.

Director: After this certificate Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) or Attending Physician; Be examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 Yes patient 2 ER/Outpatient 3 DOA ည 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural work?
1 Yes 2 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined To the Hospital o within 24 hours af To the Funeral D completely filled i Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: Dn the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying furge Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of 29d, Data 2012 who completed cause of death (Item 23a) (Type, Print) 31. Date filed (A State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 28 Month Physician/ 2012 12:10 PM February Gloria Shaw Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Bethesda Suburban Hospital 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number Funeral Months Hours Min. 03/04/1924 New York 067-16-2672 Director 1 □ M 2 🕱 F 87 Yrs Usual Residence of Decede 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location must be notified at Director 1√2 Yes 2 □ No MD Rockville Montgomery 10f. Zip Code 10g. Citizen of What Country? 5 10e. Street and Number 23a Funeral United States 11801 Rockville Pike #1502 20852 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian ural", or iten I Examiner n Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. β 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced "natural", Completed other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working (Specify only highest grade completed) I Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home h and Mental Hygier 7 is marked other t Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Tillie Goldfarb Herman Toline 19a. Informant's Name/Relationship (Type, Print)
Lois Gutmann - Daughter 19b. Mailing Address (Street and Number or Byral Boute Number City 2078 ye (State, Zip Code) 1 and 2 s of Health item 27 20a. Method of Disposition
1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1
Department of Important: If it any injury or o Judean Mem. Gardens 03/01/12 Olney, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Edward Sagel Funeral Direction Inc
1091 Rockville Pike Rockville MD 21. Signature of Funeral Service Licensee M01163 20852 Jamie Arthurs 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Cardiorespiratory Arrest .Ph, sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Bowel Perforation Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events E C and Due to (or as a consequence of): CERTIFICATION resulting in death) Last attending physician Physician/Medical February 28, 2012 Division of Vital Records, P.O. Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day for Month Year 4 ☐ Pregnant at time of death 9 ☐ Unknown signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performe has within 24 hours after death.

To the Funeral Director: After this certificate Yes 26. Place of Death (Check only one) To Be 25. Was case referred to medical shaw, Gloria examiner? 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔀 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA completely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d, Describe how injury occurred X Natural 5 Pending work?
1 Yes 2 No Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 \square Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner To the certification of the certificati (Check Certifying Nurse Practitioners To the best of my knowledge 29c. License number 29d. Date signed (Month. Day, Year) 29b. Signature D72041 2/28/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shanthis Nadar MD 8600 Old Georgetown Road Bethesda MD 20814

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

2

Registrar's Signature

DHMH 17 Rev 7/2009

State Registrar Fischatsion

31. Date filed (Month, Day, Year,

1646

mathew

9901

meharimo

32. Registrar's Signature

Medical Ctr

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Vear Physician/ 3:57P [™] KLAVDIYA SOKOLOVA 28, MARCH 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SUBURBAN HOSPITAL MONTGOMERY **BETHESDA** If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min Director 219-45-4971 1 □ M 2 🗓 F 92 03/18/1920 Yrs. UKRAINE Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 🗆 Yes 2 🙀 No MD MONTGOMERY ROCKVILLE 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 199 ROLLINS AVENUE, #68 638 20852 USA death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black. White, etc. ō þ 1 Never Married 2 Married Maryland 21215-0036 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 🛣 No Specify: WHITE Specify: "natural" 3 X Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) ACCOUNTANT FACTORY BOOKKEEPING 8 other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F မ NAUM FEGE FREIDA MEZHERICHER : Page 1 and 2 should be tment of Health and Men tant: If item 27 is marke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NATALIYA CHERNYAVSKAYA/DAUGHTER 3031 BORGE ST., UNIT 308 OAKTON, VA 22124 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department o Important: If any injury or injury or BALTIMORE HEBREW CEM. 3/30/2012 REISTERSTOWN, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Signature of Funeral Service Licen 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ Terrosc cardion Oi 1 disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner Due to (or as a consequence of) cause. Enter Underlying NA Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical 68760 the g as ding IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?

1 Yes 2 No õ Month Day Year Pregnant at time of death signed by the at d be detached f 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has e 2 page 2 performe certificate 1 Tyes e Hospital or Attending Physician: 24 hours after death. • Funeral Director: After this certificietely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 \(\) Nursing Home 5 \(\) Residence 6 \(\) Other (Specify) 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 Yes 2 No @Kolova_ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Deficial Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 03/28/2012 55410 111. Gincherman 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Leygeniy State Registrar

1557 pm

3-38-13

Klavdiya

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Seglinksi Michael **Physician** March 26 2013 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number, **Examiner** Johns Hopkins Bayview Medical Center **Baltimore** If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 🔀M 2 🗆 F 63 July6,1948 Maryland 214-58-5696 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County ¹X Yes 2 □ No Director Md. Baltimore City 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number 21224 607 South Grundy Street U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Maryland 21215-0036 Specify. Specify: þ White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) nd Mental Hygiene. marked other than Police Officer City of Baltimore 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Be Pages 1 and 2 should be filment of Health and Mental Haut: If item 27 is marked ott Elizabeth Hufnagel Francis V. Seglinski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Baltimore, Maryland 21220 6900 Circle Road permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr. once. Ann Seglinski - Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition

1 Number 2 Cremation 3 Removal from State 20c. Location - City or Town, State March 31,2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Kaczorowski Funeral Home, PA M00933 1201 Dundalk Avenue Baltimore, Md.21222 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Piratory Failure Res Ihour **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Pulmonacy Chronic Obstruc squentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of or Attending Physician: The law requires that the death certificate be executed attending physician and I for use as the burial-trar Due to (or as a consequence of) Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? 4 Pregnant at time of death 5 Other (specity) detached 2 🗌 No Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ should be 2 No 3 Probably 4 dnknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 100 page 2 s 1 Yes 2 □ No 1 Yes 25. Was case referred to medica 26. Place of Death Check onl one funeral director, Be examiner? 1 ☑ Yes 2 ☐ No Hospital: 1 \square Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 SER/Outpatient 3 □ DOA ၉ this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Injury 1 🗌 Yes 2 🗌 No death. 2 Accident rector: A 28f. Location (Street and Number or Rural Route Number, City or Town, State) Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital within 24 hours a

To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 🗆 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ress of person who completed cause of death (Item 23a) (Type, Print) 4940 Eastern Avenue, Baltimore, MD, 21224 MEM (muaro 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001 11595 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Manyland / Department of Health and Mental Hygiene

aurie Ann Smith	1- For Sta Registrar		St	ate of	f Maryland			ent of H		na went	_	Reg	g. No.	201	2 100	- Constitution
Physician/	1. Deced	ent's Name	(First, Middl		1-						2. [Date of Death Month Iarch 24, 2	Day	Year	3. Time of Death 0517 hrs	
Medical Examiner			Ann S		Π treet and numb	er)		4b. (City, Town, o	or Location of		iarch 24, A		ounty of Deatl		\dashv
		ersity H		., 9		,		В	altimore					A/N		
Funeral Director	unk	Security N		6. Sex	7 1 2 KF	Age (In yrs.	1ast birth	- 7/	f Under 1 Ye Months Da		Mira	Date of Birth		Foreig	rthplace (State or gn puntry) MD	
ny.	Usual Re	esidence of	Decedent 10b. County			10c. City	, Town	or Location					-		10d. Inside City Limits	s
Maryland 28a-f show any d at once. rector	MD N/A B					altim	nore					1 XYes 2 No	О			
larylar 18a-f.	10e. Street and Number				10f. Zip Code						10g. Citizen of What Cou					
3a or 3	250	06 W	. Pra						2122				- 1	U.S.A		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "matural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be audified at once. To Be Completed by Funeral Director		a! Status ever Marrie	ed 2 X M		12. Was Decede Armed Force	ss?	J.S.			lispanic Origi an, Mexican,			12	White, etc.	rican Indian, Black,	
ter dea	3 Widowed 4 Divorced			orced If	1 Yes Yes, Give Year	2 X No		1 Ye	s 2 📉 N	lo specify:			S	oecify: Bla	ack	
ntural"	15. Dec		lucation (Spe		r Dates: highest grade o	completed)	16a. I	Decedent's t	Jsual Occup	oation (Give k	ind of work	done	16b. Kin	d of Business	/Industry	
5-0036 ed within 72 hours stygiene. other than "natu the Medical Exam Completed	Eleme		condary (0-12) College (1-4 or 5+) ade Nurse's Ass.								a+	Miii	rsing	Home		
1 withing giene.	17. Fathe	n Gra	First, Middle	Last)			٠	IVU	ISE S			st, Middle, M			110me	_
MD 21215-0036 nd 2 should be filed within 7 sith and Mental Hygiene. nn 27 is marked other than nammatic event, the Medica	Je		SMit								_	M. W				
21,21,30 mould to Men tite ever	1		me/Relations				1							or Town, State		
MD 2 sh and 2 sh alth an alth an		dsor		er(I	Husban			006 W				Balti ate		cation - City o	21223 r Town, State	_
Ore,				3 🗌	Removal from	State	cremate	ory or other	place)		03/20	3/12	Ba.	ltimor	~e MD	
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite	4 D	onation 5	Other S	oecify: Licensé	• A service processor proc	HAI	buc								ome PA	_
Depa Depa		111	SIAU)8/k		and the same of th		214	0 N.	Fulte	on Av	ve.,	Balt	timore	MD 212	
Physician	23a. Par	I. Enter the	e isease, or ly one cause	complication each	ations that caus	ed the deat	h. Do no	ot enter the r	node of dyin	ig, such as ca	ardiac or res	spiratory arre	st, shock	k, or heart	Approximate Interval Between Onset and	
/Medical Examiner	Immedia	te Cause (Final disease ng in death)	a. C	omplication			mity injui	ries	_					Death	_
				b.	ue to (or as a co	risequerice	OI).									
ner l	if any, le	ially list co ading to im Enter Unde			ue to (or as a co	nsequence	of):									
0, t be executed sician and burial - transit edical Examiner	(Disease	or injury t	hat initiated death) Last	G.	ue to (or as a co	nsequence	of):									П
68760, certificate be executed nding physician and se as the burial - transit				¬ ₫		-				<u></u>						
O, the ex ysician burial	U	NPENDED			AMENDED	some of pro	ananav						23d.	Date of delive		_
876 tificat ng phy as the	IF FEMA 23b. Was	NLE: decedent 12 months	pregnant in t	he	23c. If yes, out			E Fetal	death 3	3 Ectopic	pregnancy			onth	Day Year	
). Box 6876 the death certificat by the attending phy ched for use as the Physician/M	1 Y		''. No 9 ✔ Un	known	4 Pregnan 9 Unknow	t at time of d	ieath ¿	5 Other	(Specify)							
Records, P.O. Box 6876 The law requires that the death certificate cate has been signed by the attending phypage 2 should be detached for use as the completed by Physician/M	Part II. C		ficant condi		ontributing to d		resultin	g in the und	erlying cause	e given in Pa	irt I.	23e. Did to			the cause of death?	_
P.C es that igned be deta												1 Yes	2	No 3 Pro	obably 4 Vnknown	
requir requir been s should									_			24a. Was a autop	sy	prior to	autopsy findings available completion of cause of	
Records, The law requires freate has been sig yage 2 should be Completed												perfor	med? 2 ✔ No	death?	/es 2 No	
tal Records cian: The law requi certificate has been rector, page 2 should Be Complete		case refer	red to medica		spital:					Other				- 0 O#		_
of Viting Physics After this vineral dire	1	_	2 No		spital: 1 ✓ Inp			utpatient 3 Time of Inju		njury at Work	Nursing H	d. Describe h	Residen		er.	
Division of Vital Records, P.O. tall or strending Physician: The law requires that the safer death. *I Director: After this certificate has been signed by lled in by the funeral director, page 2 should be detach bertification: To Be Completed by P	1 🔲	Natural		ding	28a. Date of (Month, D Dec 23, 20	ay,Year)		1 hrs	· 1 –	Yes 2	Pe	destrian s				
/isic r Atte ter dea irector in by th	2 🗹 /	Accident Suicide		stigation	28e Place o	of Injury - At	home, fa	arm, street,	factory, office	e building, et		or Town S	tate)		Rural Route Number, Cit	у
Division o spital or Attending hours after death. neral Director: After filled in by the function: Certification:	4 🗆	Homicide	dete	ermined	(Specify)		_					23 Rt. 40 at	Rolling	Road, Balti		_
				hysiciar aminer: (n: To the best o	f my knowle examination	edge, de and/or i	ath occurred investigation	I at the time, i, in my opini	, date and pla ion, death oc	ace, and du curred at th	e to the caus e time, date	e(s) and and plac	manner as sta e, and due to t	ated. the cause(s)	
To the Ho within 24 To the Fr completel	29b. Sig	2 (title of certifi	a	and manner stat					ense number					onth, Day, Year)	
		an	DZ_	•	_				0.0	C.M.E.			Marc	h 25, 2012	!	
λ		ne and addi	ess of perso	n who co	mpleted cause Medical Ex	of death (Ite	900 V	V. Baltim	ore Stree	et. Baltimo	re, MD 2	21223				
^ State			th, Day, Year,			strar's Signa			- 12	.,						_
Registra			n 0 2	2012	Dear	my f	Ø. A	park								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 0053 March 2012 Sandra Stoops Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE N/A SAINT AGNES Hospita Age (In yrs. last birthday) Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 216-60-6987 (Month, Day, Year) Hours Min. Director 1 □ M 2 🕱 F Yrs. 60 10/24/1951 Maryland 28a-f show 10d. Inside City Limits 10c. City, Town or Location at 10a. State Director Examiner must be notified 1 XYes 2 No MD N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code o 23a Funeral 343 Yale Ave. 21229 U.S.A. items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. 11. Marital Status Armed Forces Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ō þ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🙀 No Specify: Specify: Black "natural", 3 Widowed 4 Divorced Completed other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) 2 should be filed within 72 th and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) some college Home maker Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) မ Helen Wilson Edward Toppin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12906 Boggy Trail Way, Germantown, MD 20876 Eddie Stoops Jr. (son) 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State permit. Page 1 Department of Important: If ii any injury or or Western Star Cem. 04/02/12 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD Signature of Funeral Service Licensee Joseph Ad Hess of Brown Jr. Funeral Home PA 2140 N. FUlton Ave., Baltimore, MD 21217 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, enocy, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ PANCREATIC CANCER END STAG & Y 801 disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate attending physician and for use as the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) Month Sandra signed by the at Id be detached for 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed within 24 hours after death.

To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2. Yes 2 🗷 25. Was case referred to medical 26. Place of Death (Check only one) To the Hospital or Attending Physician: Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No မ 1 Inpatient 2 ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred 1 🔀 Natural 5 \square Pending Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one 29b. Signature and title of centifie 29c. License number 29d. Date signed (Month, Day, Year) MANCH 27, 2012 D50293 3 m 30-Neme and address of person who completed cause of death (Item 23a) (Type, Print) 34 ITIMONE AGNES 1Scn oursence 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 0 2 2012

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Physician/ Conds 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Good S amartan Baltimore n/a 8. Date of Birth (Month, Day, Year) Aug 9, 1928 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral Months Hours 1 🕎 M 2 🗆 F Mary land Director 220-20-5320 83 Aug Usual Residence of Decedent Show 10a. State 10b. County 10c. City, Town or Location or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits Director Baltimore Perry Hall 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21236 U.S.A. 3901 Hannon Court, Unit G 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give 50 - 52
Year or Dates. If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black White etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 XWidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Tug Boat Operator Tug Boat Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o ၉ Paul Sullivan Jeanette Reynolds 19a. Informant's Name/Relationship (Type, Print) Department of Health ar Important: If item 27 is any injury or other traumonce. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 890 Dark Star Ave., Gahanna, Mary L. Hunker-daughter Saltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗶 Burial 2 🗆 Cremation 3 🗆 Removal from State Parkwood Cemetery 4/3/12 Parkville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral S Ace Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. William G. Dau 1050 York Rd. Towson, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions. rany, leading to immediate cause. Enter Underlying Cause (Disease or iinjury use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day Year detached 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? by should be Division of Vital Records, 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate Yes 1 Yes within 24 hours after death.

To the Funeral Director: After this certificd completed filled in by the funeral director, I the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: မ 1 Manatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie March 30, 2012 D0052573 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person 5601 Coch Acuen Blad. Baltimore, MD Z1259 Jaima am 3 31. Date filed (Month, Day, Year) 32, Registrar's Signature State Registrar DHMH 17 Rev 7/2009

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 29d per me,g926,04/16/2012dhb
Certificate of Death
Reg. No. For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 11:45 am 2012 Mary Lorraine Thompson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Towson** 4c. County of Death **Examiner** Gilchrist Hospite If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb. 5, 1925 Social Security Numbe 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Country) Maryland Days Hours Min 219-14-9697 1 □ M 2 🗚 Director 87 Feb. or 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location the Maryland Director be notified Owings Mills 1 Yes 2 No Baltimore Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 21117 23a 4 Pegram Ave. permit. Page 1 and 2 should be filed within 72 hours after death with items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ "natural", or 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced r than "natura the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the Nonce. Own Mome Momemaker Be 18. Mother's Name (First, Middle, Maiden Surname)
Dena Dayhoff 17. Father's Name (First, Middle, Last) 2 Harry F. Wright 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4 Pegram Ave. Owings Mills, MD. 21117 Lisa Pittinger - daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place)
Lake View Mem. Park April 3,2012 Sykesville, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Eckhardt Funeral Chapel F.A. Signature of Fugeral Service Licenses 11605 Reisterstown Rd. Owings Mills, MD. 21117 . Harth 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed the burial-trai Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 inding pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic preudo 5 Other (specify) atten in the past 12 month for Month Pregnant at time of death Day Year signed by the at Id be detached for 1 ☐ Yes 2 ☐ Unknown Part II. **Other significa<u>nt</u> conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown plnous 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has funeral director, page 2 autopsy Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 3 18/2012 1 Natural 2 Accident 5 Pending fal UNUNOWW 1 Tes 2 📉 No Investigation after death 6 🗆 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Nu City or Town, State) 1234W65h175 W.L.S. + MIPS+ER, MP 2115 filled in by 4 Homicide determined determined building, etc. (Specify) City or Town, State) 12 3 4 4 6 6 M W.25 + m; ns + e., M.V. Z.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hours at To the Funeral D completely filled it Medical 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. gnature and title 29d. Date signed (Month, Day, Year) D0071287 March 30, 2012 W 23a) (Type Print) and address of person who completed cause of death st. &4105 Balthreve. MD 21204 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend &8&9 PerFH C926 4/05/2012 JH State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ODAM Physician/ are 201 Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number, **Examiner** Baltmore If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Sex Age (In yrs **Funeral** Months 1 🗆 M 2 🗓 Hours 11/03/1924 Mary land Director Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Director notified 1 Yes 2 No 28a-f HNORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe ms 23a or must be n ö # by Funeral 8800 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status "natural", or iten edical Examiner r Armed Forces? Black, White, etc 1 Never Married 2 Married Yes 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗖 No Specify White If Yes. Give Specify: Completed 3 🗆 Widowed 4 🗆 Divorced Year or Dates. Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natur
any pinury or other traumatic event, the Medical
once. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, ပ္ ONES 19a. Informant's Name/Relations ip (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State 12012 4 Donation 5 Other (Specify) -ASKION FUNERAL Signature of Eugera 21. 21222 34 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Alzheimers Physician/ Dementia disease or condition Due to (or as a consequence of): Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Lines underlying Examiner Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical $\#\% + \emptyset$ Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 5 Other (specify) ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Cardiovascular Disease 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has after death.

Director: After this certificate | 1 ☐ Yes 2 ☐ No Yes within 24 hours after death.

To the Funeral Director: After this certifict completed filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? 2 No Other: 1 🗆 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 27. Manner of Death 28b. Time of 28d. Describe how injury occurred injury 1 Natural 5 Pending 2 🗌 No Investigation 2 Accident Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 28 2012 npleted cause of death (Item 23a) (Type, Print) of person who con 8800 Walther Blid, Parkville MO 21234 Michealle Harribun 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month EBO RAH PATRICI THARP ,4 M amh Medical 4a. Eacility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Age (In yrs. last birthday) 1 - M 2 F Months Days Hours Min **Director** or 28a-f shov 10b. County 10a. State death with the Maryland iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Pes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20 21222 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: "natural". Completed 3 Widowed 4 Divorced permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Euneral Service Lice 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Syn drome 5epsis disease or condition resulting in death) 24/2 Medical Due to (or as a consequence of) Examiner 24 Krs Aspiration Sequentially list conditions, Examiner If any leading to immedia cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-transit Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed emphysomatous lyny diseas Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 🕱 No Month Day Year ed by the a detached f 9 Unknown 9 Unknown s been signed by t should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Substance abuse 1 XYes 2 No 3 Probably 4 Unknown 1000H3 24b. Were autopsy findings available prior to completion of cause of death? amse 24a. Was an has performed Aroncular 1 Yes 2 No Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 2 X No မ 1 Tes 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 03,26,2012 D0070831

State Registrar DHMH 17 Rev 7/2009 MMAHOM

821 NEWTOW ST #308 Bullimore MD 21201

1DDW GAV 4

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend Items 25,27,28a-f per me, g925,03/29/2012dhb

Certificate of Death

Reg. No Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 201 lova Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Bultimore 16 5009 Famikford Himore Trank Force (NH) 9. Birthplace (State or Foreig Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 □ M 2 🛣 92 0470871919 West Virginia 235-26-1634 Director Usual Residence of Decedent 28a-f show t of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Director 1 XYes 2 No **Paltimore** Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 124 S. Collington Avenue 21231 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White Specify: Completed 3
▼ Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Domestic Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ၉ Rose Scully John Meyers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6923 Rank Street Baltimore, Maryland 21224 Harry Atwell - Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Important: If it any injury or o 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State Oak Lawn Cemetery 01/10/2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee David J. Weber Funeral Homes P.A. 401 S. Chester Street Baltimore, Maryland 21231 plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a Part 1. Enter the disease of complications that caused or heart failure. Set only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pttysician/ disease or condition resulting in death) Medical Due to (or as Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury or Attending Physician: The law requires that the death certificate be executed and for use as the burial-tran YOVED BY MEDICAL EXAMINER that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical + 33 $\mathcal D$ Division of Vital Records, P.O. Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) Pregnant at time of death Yes 2 No To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached 9 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 \square Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 110 Yes 2 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA after death.

Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: atural 5 Pending 12/2011 **Unknown** M Subject fell 2 X Accident 1 Yes 2 X No Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 5009 Frankford Ave. Baltimore, MD determined Nursing HOme the Hospital within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year)

State Registrar person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

00 (

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 29^{Day} Manth Physician/ 20 ĬZ 2:00 P M Taylor Imogene В. Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel Pasadena 1130 Wharf Drive If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Hours Min (Month, Day, Year) 84 419-34-1691 Director 1 🗆 M 2 🔀 F Dec. 12, 1927 Alabama Vre Usual Residence of Decede or 28a-f show notified at 10d Inside City Limits 10a. State 10h County 10c. City. Town or Location Director 1 Yes 2 No Maryland Anne Arundel Pasadena + 23a o. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21122 United States 1130 Wharf Drive must 1 items within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status "natural", or iter dical Examiner Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced White Completed and Mental Hygiene. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Healthcare Nurse Be filed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked or any injury or other traumatic eve ပ Myrtle L. Bradford Grover C. Bradford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1130 Wharf Dr., Pasadena, Maryland 21122 Edmond L. Taylor / Husband 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of April Date 3, cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 2012 5 Other (Specify) Glen Haven Mem. Pk. Glen Burnie, Maryland Rirkley-Ruddick Funeral Home, P.A. 421 Crain Hwy., S.E., Glen Burnie, Signature of Fineral y rvic Licensee MD 21061 Approximate Interval Between Onset and Death 23a. Part 1-Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Chronie Physician/ А disease or condition Medical resulting in death) Examiner Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of) physician s the burial Physician/Medical P.O. Box 68760 as attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Fctopic pregnancy in the past 12 months? or Month Day 5 Other (specify) Pregnant at time of death the the 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an page 2 s autopsy performed certificate Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital: 1 Yes 2 No 은 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) n 24 hours after death.

• Funeral Director: After tholetely filled in by the funeral 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending work? 1 Yes 2 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2

To the F

complete only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D 21613 me 30. Name and address of person who completed cause dideath (Item 23a) (Type, Print) Loraine M. Dailey, M.D., 24A Magothy Bridge Rd., Pasadena, Maryland 21122 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 0 2 2012 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Penelope Clark Turner March 28, Da 2012 Year 12:20 pm Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Broadmeade Cockeysville Baltimore Social Security Number If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign Funeral 8. Date of Birth 1 □ M 2 □**X**F May 9, 1925 Director Yrs Louisiana 437-22-4506 86 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 72 hours after death with the Maryland Director 10d. Inside City Limits MD Baltimore Cockeysville 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13801 York Road 21030 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White "natural", Completed 3 XWidowed 4 Divorced Specify: the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own home other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ William Τ. Clark Nellie Α. Grayson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health as Important: If item 27 is any injury or other trau once. Virginia S. Turner-daughter 29 Dublin Drive, Lutherville, MD 21093 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Hilltop Serv Corp 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 3/29/12 Towson, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Light Gee William G. 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Dau 1050 York Rd. Towson, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner Due to or as a consequence of cause. Enter Underlying sician and burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day by the Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No Division of Vital 25. Was case referred to medical 8 26. Place of Death (Check only one) examiner? 10 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 2262 completed cause of death (Item 23a) (Type, Print) YORK RD, COCKEXSVILLE MO 32. Registrar's State

DHMH 17 Rev 7/2009

Registrar

0

2013

March 28,

Physician/

Medical

Director

Funeral

Completed by

Be

ပ

Examine

Be Completed by Physician/Medical

ဂ္

Certificate:

Medical

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

GAURAV CHAUDHARY, MBBS

Examiner

Funeral

Director

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/ Medical Examiner

_ For	Please Type or State of	Print in Black In Maryland / Dep				_	ible.		
State Registrar		,	rtificate of l		, 0	eg. No. 2	112 10025		
Decedent's Name (First, Horace Wiggi	, ,				2. Date of Death Month	Day	3. Time of Death 13:30 PM		
4a. Facility Name (if not inst	itution, give street and numb	per)		r Location of Death	1	4c. County			
	TTAL OF BAI			MORE	Labor (Blue	n	/a		
5. Social Security Number 245–20–0114 Usual Residence of December	1 € M 2 □ F	7. Age (In yrs. last birthday) 85 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 109/10/1	^{Year)} 926	9. Birthplace (State or Foreign Country) NC		
10a. State 10b. C		10c. City, Town or Lo	cation	1			10d. Inside City Limits		
MD	n/a	Bal	ltimore				1 X Yes 2 □ No		
10e. Street and Number			10f. Zip Code	1.5	1	Og. Citizen of W	/hat Country?		
3411 Springe			212			USA			
11. Marital Status 1 Never Married 2 3 Widowed 4 Div	Armed Ford	ces? 2 No	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🔀 No	an, Mexican, Puerto	ecify Yes or No- o Rican, etc.)	Blac	e - American Indian, k, White, etc. Black		
	ecedent's Education / highest grade completed)	(Give	dent's Usual Occup kind of work done	during most of world	king	16b. Kind of Bu	siness/Industry		
Elementary/Secondary (0	0-12) College (1-	+ Or 5+1	o NOT use retired) Painter		E	ethlehe	em Steel		
17. Father's Name (First, Mi	ddle, Last)			18. Mother's Nan	ne (First, Middle, M	aiden Sumame)		
Hardy August	us Wiggins			Mary Le	e Holley				
19a. Informant's Name/Rela			ng Address (Street Springda						
20a. Method of Disposition	nation 3 🗆 Removal from S	20b. Place of Dispo cemetery, crer	matory or other place	ce)	I .		City or Town, State		
4 Donation 5 □ O	ther (Specify)	Garrison Fo	rest Va Cen	etery April	L 6, 2012 C	wings N	Mills, MD		
21. Sign ture of funeral Se	rvice License		Ohine and Addy						
23a. Par 1. Enter the disea shock, or heart failure Immediate Cause (Final disease or condition resulting in death)		aused the death. Do not ente		g, such as cardiac			Approximate Interval Between Onset and Death		
Sequentially list conditions of any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C. Due to (c	b. SMALL BOWEL OBSTRUCTION Due to (or as a consequence or).							
resulting in death) Last	Due to (c	r as a consequence of):							
F FEMALE: 3b. Was decedent pregnar in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live B	ant at time of death 5	☐ Ectopic pregnand ☐ Other (specify)	cy		23d. Dat Mor	e of delivery hth Day Year		
_	onditions contributing to de		,				bute to the cause of death? 3 Probably 4 Unknown		
					24a. Was an autopsy perform	ped? p	Vere autopsy findings available rior to completion of cause of eath?		
25. Was case referred to me examiner?	edical Hospital:			ace of Death (Chec	ck only one)		The state of the s		
	1 1 1 28a. Date o	npatient 2 ER/Outpatier finjury 28b. Time of injury injury	28c. Injur work	4 ∐ Nursing H y at :?	ome 5 Resider 28d. Describe hov				
3 Suicide 6 0	nvestigation Could not be determined 28e. Place of building	of Injury - At home, farm, str g, etc. (Specify)		M 1 Yes 2 No 2 Rectory, office 28f. Location City or To			r or Rural Route Number,		
(Check 2 ☐ Mec	tifying Physician: To the be dical Examiner: On the basis tifying Nurse Practitioner:	of examination and/or invest	tigation, in my opinio	on, death occurred a	at the time, date and	place, and due	to the cause(s) and manner stated.		
29b. Signature and title of co	ertifier	BP35	29c. License		29	d. Date signed	(Month, Day, Year)		

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760

Registrar

State

DHMH 17 Rev 06-2011

parker

SINAL HOSPITAL OF BALTIMORE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Physician/ Month 3 1542 M 29 VIVAIVIIA Williams Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Adventist HOSP Carroll 7400 Montgomery Washington If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **8 4 Funeral** 219-22-8666 1/25/28 Hours Min CIN CON) 1 🗆 M 2 🏪 F **Director** 28a-f show 10a. State 10b. Count 10d. Inside City Limits 10c. City, Town or Location notified at Director N/A Baltimore MD 1 Yes 2X No 10e. Street and Number 0 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be r 21213 1315 N. Patterson Ave Funeral USA death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian, Armed Forces? African þ ☐ Never Married 2 ☐ Married within 72 hours after Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates Widowed 4 Divorced "natural", Amer. Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) n and Mental Hygiene.
7 is marked other than "I Self Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker permit. Page 1 and 2 should be filed wil Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, <u>tt</u> once. Be 17. Father's Name (First, Middle, Last) 8. Mother's Name (First, Middle, Maiden Surname)
Modae Mitchell .0 Max Mitchell 19a. Informant's Name/Relationship (Type, Print)
Pamela Bright/Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1315 N. Patterson Ave, Balt., MD 21213 altimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 1 Burial 2 Cremation 3 Removal from State Mt. Zion Cem. 4/7/12 Balt.,MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hari P. 5126 Belair Rd, Balt: eral Service Licer , Close 2F6 SysaPA 21. Signatur 23a. Par 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician) Due (or as a consequence of): infarction disease or condition Medical resulting in death) Examiner ESRD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burfal-transi Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 16 diabete IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, fallure respiratory Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an diabetes type autopsy performe advanced dementa Yes 2 No 25. Was case referred to medical examiner?
1 ☑ Yes 2 ☐ No 26. Place of Death (Check only one) Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 POOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending 2 Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number 7220 3 2012

Registrar

DHMH 17 Rev 06-2011

State

10

Carroll

32. Registrar's Signature

20912

Park

Takoma

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7600

Ansaldo

31. Date filed (Month, Day, Year)

APR 0 2 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<u>012</u> Month JEANNE NORWOOD TRIBULL WELSH March 31 1:55P M 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death GILCHRIST HOSPICE CENTER Baltimore County Towson Social Security Number 7. Age (În yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Months Hours (Month, Day, Year) 220-18-8259 1 □ M 2 🛛 F 84 Yrs. Sept 13, 1927 Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore County 1 Yes 2 No Maryland | Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 800 Southerly Road 21286 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 □ Divorced Specify. Year or Dates. White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Secretary Brokerage firm 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Tribull Christine Norwood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lori W. Martinet 200 Sandee Road, Timonium, Maryland 21093 (Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Green Mount Crematory 4/3/2012 Baltimore, Maryland 21. Signat Fire al S Value ne MITCHELL-WIEDEFELD FUNERAL HOME INC 6500 York Road, Baltimore, Maryland 21212 Martin D. Lawson 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death NGOSTIVE HEART FAILURE disease or condition 10APC Due to (or as a consequence of) Duri to (or as a nonsequence of) Due to (or as a consequence of)

Physician/ Medical **Examiner**

Physician/

Medical

Director

Funeral

þ

Completed

Be

မ

Examiner

Funeral

Director

28a-f show

permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must he notified at

Maryland 21215-0036

Baltimore,

Box 68760

P.0.

Division of Vital Records,

Physician/Medical Examiner þ Completed Be မ

nse fo page 2 filled in by

the Hospital or Attending Physician: The law requires that the death certificate be executed this 24 hours after death. Funeral Director: After within 24 hou

To the Funel

completely fi

State Registrar

29b. Signature and title of certifier

filed (Month, Day, Year)

APR 0 2 2012

resulting in death) Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mor 5 Other (specify) Pregnant at time of death Month Day Year 2 W q 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? F IBRILLATION 1 Yes 2 No 3 Probably 4 Unknown PULMONARY HYPERYONSION 24b. Were autopsy findings available prior to completion of cruse of death? 24a, Was an CHRONIC 2 1 No 1 Tes Was case referred to 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 2 1-No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Matural 5 \square Pending Accident Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗌

DHMH 17 Rev 06-2011

32. Registrar's Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 8:15 PM ashington March Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. Cit Town, or Location of Death HOS rince Pital enter . Sex 1 **№** M 2 □ F 1 Year If Under 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Min (Month, Day, Director Usual Residence of Decedent items 23a or 28a-f show 10a. State 10b. County 72 hours after death with the Maryland 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No argo 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 0744 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. 0 Completed by 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: If Yes, Give "natural", 3 Widowed 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) arrier Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Sims ashinate 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 59 Spring Valley Ave Irvina Hackensack New Jersey 07601 Important: If item 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 Department of F 5 1 X Burial 2 Cremation 3 Removal from State Suitland, Maryland injury 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Add ess of Facility obert B Bay 2605 S. Shirlington Read Arlington, Virginia 22206 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ∉nysician/ disease or condition resulting in death) Medical Due to for as a consequence of Examiner ound Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of, To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi attending physician and that initiated events Due to (or as a consequence of): Physician/Medical for use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Day Month Year 2 No the detached 9 Unknown i signed by the Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 1 Yes 3 Probably 4 Unknown Completed in by the funeral director, page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: ၉ ✓ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, this s after death. 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral L completed filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗌 only one) 29b. Signature and title of certific 29c. License number 29d. Date signed (Month. Day, Year) address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Registrar'

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

State Amend Item 25 per me, g925,03/29/2012dhb

Registrar Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 03 Day Physician/ 2012 07 9:20 A Wilcher Lillie Mae Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Cheverly Prince George's Hospital 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birting Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday **Funeral** Min Days Hours 03 1 🗆 M 2 🗆 🗶 F 1940 578-52-3675 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State Director 1 X Yes 2 No DC Washington 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number Funeral USA 20011 5502 Fourth St. NW Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces Black, White, etc. 1 Never Married 2 Married Yes 2 X No ò Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Black If Yes, Give 3 Widowed 4 X Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government Financial Analyst 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Juanita Whitfield Thomas James 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5815 Coolidge St. Capitol Heights, MD 20743 Anthony Wilcher/Son 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State Washington, DC 03/15/2012 4 Donation 5 Other (Specify) Rock Creek Cemetery 22. Name and Address of Facility Marshall-March Funeral Home 21. Signature of Funeral Service Licenses 4217 9th St. NW Washington, DC 20011 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequ **Examiner** Sequentially list conditions Examiner Due to for as a consequence of if any, leading to immediate cause. Enter Underlying attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year 5 Other (specify) Pregnant at time of death been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Sunknown cate has been siç ; page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 Ves 2 No Director: After this certificate Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 욘 within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral i 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? injury 1 ี Natural 5 Pending 2 🗌 No Investigation ☐ Accident ☐ Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of cert

Registrar
DHMH 17 Rev 7/2009

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

3001

eqistrar's

Badii

31. Date filed (Month, Day,

12-02405	
Joseph Walker	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

sepii waikei		1- For State Certificate of Death		201	2 1003				
Physician		Registrar 1. Decedent's Name (First, Middle,Last)	2. Date of Dear		3. Time of Death				
ledical Examin	er	Joseph V. Walker	Month March 25,	Day Year 2012	1531 hrs				
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death University Hospital Baltimore	1	4c. County of Deat	h				
		University Hospital Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs	le Date of Bir	N/A	thelace (State or				
Funeral Director		214-86-5772 1\(\text{M} m 2\(\text{F}\) 36 Yrs. Months Days Hours Min		1Forei					
Any	ŀ	Usual Residence of Decedent 10a. State			10d. Inside City Limits				
and show	۱.	MD N/A Baltimore			1 X Yes 2 No				
Maryli 28a-f d at o	Director	10e. Street and Number 10f. Zip Code	1	0g. Citizen of What Cou	ntry?				
th the		1937 Herbert St. 21217		U.S.A					
ath wit	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 1 X Never Married 2 Married Armed Forces? 13. Was Decedent of Hispanic Origin? (S		14. Race - Amer White, etc.	ican Indian, Black,				
i, or i		1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Yeer 1 Yes 2 No specify:		Specify: Bl	ack				
ours at	<u>6</u>	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of v		16b. Kind of Business	- 1				
6 72 hc	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use reti	ired)						
within jene.	Ē.	8th Grade N/A		N/A	,				
15-(ا ک ا	17. Father's Name (First, Middle, Last) Joseph Walker Mary H		Maiden Surname)					
212 Muld be Ment mark		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or I		nber, City or Town, State	e, Zip Code)				
MD 12 sho		Herbert Datcher(Brother) 1937 Herbert St.,	Balti	more, MD	21217				
re, Theal Tre		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or	Town, State				
Pager nent o	d	4 Donation 5 Other Specify: on-site Crematory 04	/05/12	Baltimor	e, MD				
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygione. Important: If item 27 is marked other than "oatural", or items 23a or 28a-f sho injury or other tranmatic event, the Medical Examiner must be optified at once.	I	21. Signature of Funeral Service Licensee 27 Name and Address of Facility Wn	Jr. F	uneral Ho	me PA				
Physician	-1	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or			Approximate Interval				
/Medical	1	failure. List only one cause on each line.		,,	Between Onset and Death				
ixaminer	1	Immediate Cause (Final disease or condition resulting in death) a Septic Shock Due to (or as a consequence of):							
	$\lfloor \rfloor$	Sequentially list conditions, bAcute Pancreatitis							
		if any, leading to immediate cause. Enter Underlying Cause Compared with the lightest of the leading to the latter of the latte							
ed sit	events resulting in death) Last Due to (or as a consequence of):								
and and	Medical	ME UNPENDED AMENDED 23a-b,pt.II,27,per me,g927 5-2	3-12 sm	1					
ox 68760, eath certificate be ex attending physician for use as the burial.	1	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the		23d. Date of deliver	y				
certificanting		23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnated by the past 12 months? 4 Pregnant at time of death 5 Other (Specify)	ancy	Month	Day Year				
Box 687 e death certific the attending p ed for use as th	Physician	1 Yes 2 No 9 Unknown 9 Unknown							
P.O. Bost that the deat	5	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	-	bacco use contribute to					
- s .g .e		Diabetes Mellitus; chronic alcohol abuse			pably 4 🗹 Unknown				
of Vital Records, og Physiciae: The law requir wher this certificate has been s meral director, page 2 should	Completed		24a. Was autop		topsy findings available completion of cause of				
tal Rec	팅		1 Yes	2 No 1 ✓ Y	es 2 No				
Vital ysicino:	8	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other,4 Nursin							
Physic Physic rer this eral dire	۹-	27. Manner of Death 28a, Date of Injury 28b, Time of Injury 28c, Injury at Work?		Residence 6 Othe	r.				
C # . ~ 4 1		1 X Natural 5 Pending (Month, Day, Year) 1 Yes 2 No		• •					
Division tal or Atteodi s after death, al Director; led in by the fi	2	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc.		Street and Number or Ru	ral Route Number, City				
Division At points ours after description or At filled in by	Certification:	4 Homicide determined (Specify)	or Town, S	tate)					
	<u> </u>	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and one) 2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at							
To or	ğΙ	29b. Signature and title of certifier 29c. License number		29d. Date signed (Mo	nth, Day, Year)				
1		Alle Granell MD O.C.M.E.		March 26, 2012					
2 olberd	1	30. Name and address of person who completed cause of death (Item 23a)							
	1	Melissa Brassell, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimo	re, MD 2122 	23					
Sta Registra	~~	31. Date filed (Month, Day, Year) Registrar's Signature APR 0 2 2012							

DHMH 17 Rev 1/2001 OCME 2006

DOME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Herman White 5:25P March 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Co. Northwest Hospital Windsor Mill If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Hours 04/08/1946 S. Carolina 65 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 Yes 2 No N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21215 2500 Belvedere Ave. U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. 1 Never Married 2 Married

1 Yes 2 No Specify:

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Janitor

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Specify: Black

County

16b. Kind of Business/Industry

20c. Location - City or Town, State

MD21709

Baltmore

Baltimore

18. Mother's Name (First, Middle, Maiden Surname)

Ida Thompson

P.O. Box 934 Andrews, S.C.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Physician/ Medical Examiner For State Registrar

10a. State

MD

11. Marital Status

3 X Widowed 4 Divorced

9th Grade

Paul WHite

20a. Method of Disposition

17. Father's Name (First, Middle, Last)

19a. Informant's Name/Relationship (Type, Print)

15. Decedent's Education

(Specify only highest grade completed)

Lou Della Miller(sister)

1 Burial 2X Cremation 3 Removal from State

College (1-4 or 5+)

Director

Funeral

þ

Completed

Be

မ

Physician/

Medical

Examiner

Funeral

Director

ral", or items 23a or 28a-f show Examiner must be notified at

"natural",

the Medical

Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me once.

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

burial-trar physician ase for

To the Hospital or Attending Physician: The law requires that the death certificate be executed eral Director; After this certificate has been signed by the a filled in by the funeral director, page 2 should be detached 24 hours after deat Funeral Director: within 2

Division of Vital Records, P.O. Box 68760

State

	4 ☐ Donation 5 ☐ Other (Specify)	√on-sit	e cr	ematory 03/	28/12 B	artimore	≥,MD
	21. Signature of Funeral Service dicensee	& house	კისულ 2140	ph ^{Ad} ffsofBrown N. Fulton	Jr. Fun Ave., Ba	eral Hor ltimore	ne PA , MD21217
	23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)			ode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
Be Completed by Physician/Medical Examiner	Sequentially list conditions, if any, eading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):					
ysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		3 ☐ Ectop 5 ☐ Other	oic pregnancy (specify)		23d. Date of de Month	elivery Day Year
ted by Ph	Part II. Other significant conditions cont	ributing to death but not resulting in th	ie underlyii	ng cause given in Part I.			o the cause of death? Probably 4 Unknown
Complet					24a. Was an autopsy performe 1 Yes 2	prior to death?	utopsy findings available completion of cause of
Be	25. Was case referred to medical examiner?	ospital:		26. Place of Death (Chec		/ in-0	High lagging
욘	1 L Yes 2 M No	1 ☐ Inpatient 2 ☐ ER/Outpa					Tient incopice
ficate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year) 28b. Time injur		28c. Injury at work? 1 Yes 2 No	28d. Describe how	injury occurred	
l Certi	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	street, fac	tory, office	28f. Location (Stree City or Town, S	et and Number or Ru state)	aral Route Number,
Medical Certificate:	(Check 2 Medical Examine	cian: To the best of my knowledge, dea er: On the basis of examination and/or in Practitioner: To the best of my knowled	vestigation,	in my opinion, death occurred a	at the time, date and p	lace, and due to the	cause(s) and manner stated.
	29b. Signature and title of certifier	110		29c. License number	290	. Date signed (Mont	
	MI Ligapularen	10	- 1	DOOS7165		2122/	17

Registrar

all

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) \$ 203

Registrar's Signature

APR 0 2 2012

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 | 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 03 Physician/ RALPH 30 10:42 A.M 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MEDICALCENTE ANNE ARUNDE BURNIE BALTIMORE WASHINGTON 9. Birthplace (State or Foreign Country) 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In vrs. last birthday) **Funeral** Director 213.30.5263 1 **XX**M 2 🗆 F NOV 78 26, 1933 Usual Residence of Deceden show 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f 1 Yes 2xx No MD ANNE ARUNDEL **GLEN BURNIE** 0 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a 208 KING GEORGE DR. 12. Was Decedent Ever in U.S. Armed Force (1 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Examiner Black, White, etc. 9 Completed by 1 Never Married 2 Married 1 Yes 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 'natural", 3 ₩Widowed 4 ☐ Divorced ould be filed wn.

ould be filed wn.

outher than "natu.

outher than "natu.

outher than "take.

outher than "take. Year or Dates WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) traumatic event, the **MAINTENANCE GENERAL MOTORS CORP** 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked ပ LESTER WATTS HAZEL VIRGINIA TRIPLETT 1 and 2 should by Health and Meinten 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DAUGHTER 7866 PEPPERBOX LN. PASADENA, MD 21122 PATRICIA WARFIELD injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of Important: If it any injury or o once. 1 XXBurial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place. **GLEN HAVEN CEMETERY** 4.2.2012 GLEN BURNIE, MD 4 Donation 5 Other (Specify) Sign (re of Funeral Service L) FINK FUNERAL HOME, P.A. GRECORY FINK 426 CRAIN HWY SW GLEN BURNIE, MD 21061 M01148 art 1. Sater the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest hock, or heart failure. List only one cause on each line. 23a. Part 1 Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Ph_sician/ MYOCARDIAL Medical resulting in death) **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Due to lor as a consequence of Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 the IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month 5 Other (specify) Pregnant at time of death 1 Yes 2 No g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ FIBRILLATION Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed INFECTION 24b. Were autopsy findings available prior to completion of cause of death?

1
Yes 2 No 24a. Was an Jas autopsy Yes 21 the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No ပ္ 1 Unpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Mann f Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation filled in by the Funeral Director; 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D69090 2012 30. Name and address of person who completed cause of death (I)em 23a) (Type, Print) DR. REDDY 301 HOSPITAL DR. GLEN BURNIE, MD 21061 32. Registrar's Signature State APR 0 2 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death March Physician/ 2:30 A.M 2012 28, Wagner <u>Margaret</u> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll County Westminster Golden Living Center Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** September 3 88 215-12-9828 1 🗆 M 2 🔀 F **Director** Maryland Usual Residence of Decedent 28a-f shov 10d, Inside City Limits 10a. State 10c. City, Town or Location items 23a or 28a-f sho her must be notified at Director 1 Yes 2 No Baltimore City Md. 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number Funeral 21230 S. 1843 Covington Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. er than "natural", or iter the Medical Examiner Armed Forces Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: 3 Widowed 4 Divorced White Year or Dates 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Own Home 9th Home Maker permit. Page 1 and 2 should be filed wir Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, ± Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Martha Baczkowski Menninger Leonard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2934 Bachman Road Manchester, MD.21102 19a. Informant's Name/Relationship (Type, Print) John T. Wagner / Son Baltimore, 205 Place of Dis**p**osition (Name of Salmeter) Commatory or other place)
Heart of Jesus 20c. Location - City or Town, State 20a. Method of Disposition Apr i^Dte 😾 Burial 2 🗆 Cremation 3 🗆 Removal from State 3,2012 Baltimore, Maryland Donation 5 Other (Specify) 22. Name and Address of Facility Kaczorowski Funeral Home, P.A 21. Signature of Funeral Seguice Licensee M00933 1201 Dundalk Avenue Baltimore, Md. 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death Immediate Cause (Final Zuch Ph ician/ disease or condition Medical resulting in death) **Examiner** Esquerition, list outdone, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last quentially flet condition Exami and the burial-trai physician Physician/Medical certificate be P.O. Box 68760 attending p as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month or Attending Physician: The law requires that the death Day Year Pregnant at time of death 5 Other (specify) signed by the at Id be detached for Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2 No 3 Probably 4 Unknown Division of Vital Records, been signated by should be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page 2 performed 1 ☐ Yes 2 ☐ No after death.

Director: After this certificate! filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural Accident injury 5 Pending Investigation 2 Accider
3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral C

completely filled the Hospital Medical 1 X certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29c. License number re and title of certifier 29d. Date signed (Month, Day, Year) 29b. Signa

Registrar DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

D 25443

John W. Middleton, M.D. 688-C Poole Road Westminster, Md.21157

March 28, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2012 Year March 30, Dorothy M. Yox 7:20 A.M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Future Care Cherrywood Reisterstown Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6 Sex 7. Age (In vrs. last birthday 8. Date of Birth **Funeral** 1 □ M 💥 F Months Days Hours Min. Oct. 9, 1915 96 Yrs. **Director** 214-12-4276 Usual Residence of Decede 28a-f shov 10a. State notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No M Baltimore Reisterstown 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? ems 23a or must be n Funeral U.S.A. 214 Butler Road 21136 items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 1. Marital Status 14. Race - American Indian, er than "natural", or iter the Medical Examiner Armed Forces? Black, White, etc ☐ Never Married 2 ☐ Married ģ Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates 3₩idowed 4 □ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ School Teacher Elementary School Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked of မ Nelson Miles Lola E. Hughes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Mary E. Gogel (Daughter) 805 Mago Vista Rd., Arnold, MD 21012 Baltimore, 20a. Method of Disposition
1 → Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 4 Donation 5 Other (Specify) 4/3/2012 Evergreen Mem'1 Grdns Finksburg, MD 22. Name and Address of Facility Eckhardt Funeral Chapel, 21. Signature of Functor Service Licensee P.A. 11605 Reisterstown Rd., Owings Mills, MD 21117 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph_sician/ Coronary Artery Disease disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Due to (or as a consequence of) Examir that the death certificate be executed sician and burial-trans Due to (or as a consequence of): resulting in death) Last physician the burial Physician/Medical Box 68760 nding p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Cther (specify) in the past 12 menths? ō Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown signed by the a d be detached t 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò or Attending Physician: The law requires Division of Vital Records, Multiple lesions to the liver 1 Yes 2 No 3 Probably Wunknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an performed? death? 2 🗌 No 1 🗌 Yes To Be 25. Was case referred to medica 26. Place of Death (Check only one) 1 Yes Other: XX Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA After this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Tes 2 🗌 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check XXcertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of

State

Registrar

Kathleen C. Diamond 2835 Smith Ave. Baltimore, MD 21209

Date filed (Month, Day Your)

32. Registy's Sign tyre

APR 0 2 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

R088852

March 30,

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

h Thomas /		State Registrar	te of Maryland /	•	tment of <i>ificate of</i>		Mental F		eg. No. 2	012	1003
Physici lical Exami	an/	Decedent's Name (First, Middle, RALPH THOMAS						2. Date of Dea Month March 21			of Death 8 hrs
		4a. Facility Name (if not institution,	give street and number)		4	b. City, Town, or L	ocation of Deat	<u> </u>			
Funeral		Route 70 East, one-half 5. Social Security Number 6		e (In yrs. last	t birthday)	If Under 1 Year	If Under 24Hr	s. 8. Date of Bi	rth(MM/DD/YYYY)	9. Birthplace (State or
Director		214-46-0710	1 M 2 F	61	Yrs.	Months Days	Hours Mi	n. 08/02/	/1950	Foreign MAR Country)	YLAND
any		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Locati	on				10d. In:	side City Limits
	٦	MD QUEEN	ANNE'S		CHE	STER				1 🔲	Yes 2 No
ith the Maryland 23a or 28a-f show	Director	10e. Street and Number				10f. Zip Code	1.0	1	Og. Citizen of Wha		
rith the	a D	408 LITTLE CREE	EK ROAD	Ever in U.S.	13. Was	216 Decedent of Hisp		Specify Yes or No	UNITED	American India	an, Black,
death w	Funeral	1 Never Married 2 X Marr	ried Armed Forces?			es, specify Cuban,			White,	etc.	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygient and the Comparament of Health and Mental Hygient Ameria Hitem 77 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once.		3 Widowed 4 Divorce 15. Decedent's Education (Specific	ced If Yes, Give Year or Dates:	nloted) 1		Yes 2 No		work done	Specify:	WHITE	
2 hour	Completed by	Elementary/Secondary (0-12)	College (1-4 or 5			est of working life.			10b, Killa of Bas	mess/maasty	
5-0036 iled within 7. Hygiene. Jother than	ğ	12		R	OOFER			ROOFI	NG		
15-C	Be Co	17. Father's Name (First, Middle, Land RALPH T. ALTON	•			11	8.Mother's Nam BETTY		Maiden Surname)		
2121 ould be fi d Mental l s marked tic event,	To B	19a. Informant's Name/Relationship			19b. Mailing	Address (Street			nber, City or Town	, State, Zip Coo	de)
MD 2 sho alth and alt and alt and alt and alth and alth and alth alth alth alth alth alth alth alth		TEENA A. ALTON 20a. Method of Disposition	/ WIFE	20h Pls		ITTLE CRI		D, CHEST	TER, MD 2		tate
Baltimore, bermit. Pages 1 ar Department of Her Important: If ite		1 Burial 2 Cremation	_	te CHES	matory or oth	er place) E CREMATI ER	ON OO	_		•	
Istim nit. Pa artmen octant	ŀ	4 Donation 5 Other Spec 21. Signature of Funeral Service Lie		1	22. N	ame and Address	of Facility		STEVEN		
W P P P I		23a. Part I. Enter the disease, or confailure. List only one cause or	1/2	<u> </u>	FEI	LLOWS, HE SHAMROC	LFENBEI K ROAD	N & NEW CHESTE	NAM FUNE R, MD 21	RAL HOM	E, P.A.
/Medical :xaminer ususit	Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to limited accuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Cardiovas Due to (or as a consect Due to (or as a consect Due to (or as a consect d.	equence of):							Death
bu, te be executed ysician and burial - transit	dical	X UNPENDED	X AMENDED#1 a	s note	ed,23a,	27,28a-f	,per me	,g928 6-	4-12 sm		
Records, P.O. Box 68760 The law requires that the death certificate trate has been signed by the attending physipage 2 should be detached for use as the bu	šľ	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcom 1 Live birth 4 Pregnant at t 9 Unknown		2 Fet	al death 3 eer (Specify)	Ectopic pregn	ancy	23d. Date of c Month	lelivery Day	Year
that the detache	by P	Part II. Other significant condition	ns contributing to death	but not resu	ulting in the u	nderlying cause giv	ven in Part I.	23e. Did to	obacco use contrib	Probably 4	_
'dS, requires seen sig	Completed							24a. Was		ere autopsy fin	dings available
ecol he law te has l ige 2 sh	dmc				-	_		autop perfo 1 ✔ Yes	rmed? de	eath? Yes	2 No
tal Reco	BeC	25. Was case referred to medical examiner?					of Death (Check	only one)			
Division of Vital Records, P.O. to or Attending Physician: The law requires that the start death. After this certificate has been signed by led in by the funeral director, page 2 should be detacted in by the funeral director, page 2 should be detacted.	P	1 ✓ Yes 2 No 27. Manner of Death			R/Outpatient				Residence 6		
SION O ttending death. ctor: Afte y the fune	ţi ii	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 28d. Describe how								in coll	ision
DIVISION OF VITAL To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certificompletely filled in by the funeral director,	Certification:	2 X Accident Investigation Investigation 3 Suicide 6 Could not be Could n								or Rural Route	Number, City
Spital Spital Operal I	Ser	4 Homicide determine 29a. Certifier Determine 29a.	(opening) FO		oadway			mile wes	st of Rte	98 L1sb	on,MD.
the Ho hin 24 the Fu	Medical	(Check only	sician: To the best of my iner:On the basis of exam								s)
To with	Mec	29b. Signature and title of certifier	and manner stated,			29c. License			29d. Date signe	d (Month, Day,	Year)
		anil				O.C.M	1.E.		March 22, 2	012	
·	ı	30. Name and address of person will Ana Rubio MD. Assis	the completed cause of destant Medical Exam			Ctt F	Caltinages NA	D 21223			
		ALL STORY OF A SSIS	vani weducat Exami			TINTE STREET -					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 20 ĬZ March 12 ay 11:05 P M Stanford Lee Adler Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Heritage Harbour Health & Rehab Annapolis If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number . Age (In yrs. last birthday) 8. Date of Birth 6. Sex **Funeral** Months Hours (Month, Day, Year) 548-24-6558 **Director** 1**X** M 2 □ F 89 9/30/1922 New York Usual Residence of Decede 28a-f shov or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2XXNo MD Anne Arundel Edgewater 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8 Lee Airpark DR. U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 x Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. WWII 1 ☐ Yes 2 X No Specify: Specify. Completed 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Medical Instrument Biomedical Engineer and Mental Hygie is marked other injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Nina Harger David H. Adler 1 and 2 should b f Health and Mer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 4919 Mariners DR. Shady Side, MD 20764 Paul Adler Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 XXBurial 2 Cremation 3 Removal from State Resurrection Cemetery 3/17/2012 4 Donation 5 Other (Specify) Moneta, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home P.A. 12 Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of). Examir burial-transi Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) anding physician use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for 5 Other (specify) Month Day signed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an his certificate has La director, page 2 s this certificate 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be (25. Was case referred to medical **Division of Vital** 26. Place of Death (Check only one) examiner? Hospital: Other: ပ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 1 Natural 28d. Describe how injury occurred injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physi To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (actitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examin Certifying Nurs only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who 5 +

Registrar

DHMH 17 Rev 06-2011

State

32. Registrar

12-02210

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Thelma Mae Allen Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Time of Death Physician/ Month Day March 17, 2012 1548 hrs Medical Examiner Thelma Mae Allen 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Washington Hagerstown 339 Vale Street 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Director 05/10/1952 Country) MD 59 217-58-2782 1 M 2 X F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 5 10a. State 10b. County 1 X Yes 2 No or items 23a or 28a-f show MD Hagerstown Pages 1 and 2 should be filed within 72 hours after death with the Maryland trnent of Health and Mental Hygene.
 Transt: If item 27 is marked other than "natural", or items 23a or 28a-f sho yer other traumatic event, the Medical Examiner must be optified at once. Washington irector 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 339 Vale Street 21740 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces' 1 Never Married 2 X Married Yes White 1 Yes 2 No specify: Specify: 3 Widowed 4 Divorced f Yes, Give Year ₫ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) ltimore, MD 21215-0036 Home Homemaker 8 th 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Bowers Harold J. McClanathan Evelyn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 339 Vale Street, Hagerstown, MD 21740 Andrew W. Allen / Husband 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 03/20/2012 Smithsburg, MD Smithsburg Crematorium 4 Donation 5 Other Specify 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Gerald N. Minnich Funeral Home Hagerstown, MD 21740 305 N. Potomac Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line **/Medical** Death a. Hemopericardium Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as e consequence of): b. Ruptured Myocardial Infarction Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause c. Atherosclerotic Cardiovascular Disease (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last • Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
• Funeral Director: After this certificate has been signed by the attending physician and and Sa UNPENDED **AMENDED** signed by the attending physician be detached for use as the burial hysician/Medi Division of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery IF FEMALE: 23b. Was decedent pregnant in the Day 1 Live birth 3 Ectopic pregnancy Month Year Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ₫ 1 Yes 2 No 3 Probably 4 V Unknown Completed has been si 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy . death? ✓ Yes 2 No 2 No page 1 Yes 26.Place of Death (Check only one) 25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other: Scene 1 🗸 Yes 2 No 28c. Injury at Work? 28d. Describe how injury осситеd 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 1 🗸 Natural 1 Yes 2 No Pending Director: Certificat 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 6 Could not be determined Homicide 29a. Certifier 1 To the Host within 24 ho To the Functional Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier March 18, 2012 O.C.M.E. Mark 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Melissa Brassell, MD 31. Date filed (Month.

DHMH 17 Rev 1/2001 **OCME 2006**

State Registrar

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 3. Time of Death 2.45 P 1. Decedent's Name (First, Middle, Last) Physician/ UKY DINOV ADIMIR 0/2 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Burtonsville Montgomery Sanctuary at Holy Cross 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** (Month, Day, Year) Months Hours Min Russian 069-54-5487 1 🕱 M 2 🗆 F Director 73 Vrs June 05, 1938 Federation Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10c. City. Town or Location notified at Director 1 Yes 2 X No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? the Medical Examiner must be Funeral items 23a 20905 U.S.A. 1701 Colesberg Street Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 X No Black, White, etc. ö þ 1 Never Married 2 Married Maryland 21215-0036 filed within 72 hours after 1 Yes 2 X No Specify: If Yes, Give Year or Dates Specify "natural", 3 X Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry al Hygiene. life. DO NOT use retired Elementary/Secondary (0-12) College (1-4 or 5+) Senior Research Director Maritime 5+ Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental ည Nina Reva Konstantin Ankudinov traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other tratonce. Silver Spring, Maryland 20905 Katherine Ankudinov - Daughter 1701 Colesberg St., Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Conation 5 Other (Specify) Lincoln Crematory 3/21/2012 Brentwood, Maryland of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. natur 100209 11800 New Hampshire Ave., Silver Spring, MD 20904 disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a Part 1 Enter he Approximate shock, or heart fa lure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final disease or condition METASTATIC ASTRI Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Dente for as a consequence of attending physiciam and I for use as the burial to Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: ves, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Other (specify) Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>8</u> Records, 1 🗌 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of Cause of death? 24a. Was an cate has I autopsy perform within 24 hours after death.

To the Funeral Director: After this certificate ı ☐ Yes 2 l **Division of Vital** filled in by the funeral director, 25. Was case referred to edical Be 26. Place of Death Check only one) examiner? ျ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? Natural injury 5 Pending 2 🗌 No Investigation Accident 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month) Dav. Year)

State Registrar 31. Date filed (Month, Day, Year)

21

DHMH 17 Rev 06-2011

1525

WINGS

MILL MA

Name and address of person who completed cause of death (Item 23a) (Type, Print)

ASNEEM AKHANI, P.OBOX

Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Mar	yland / Depa	artment of	Health ar	nd Mental H	lygiene		
		_	Registrar			tificate of			Reg. No. 2	012	1003
	Physic	ian/	1. Decedent's Name (First, Middle, La	st)	2. Date of 0		0 1 6	3. Time of Death			
at a	Med	lical	Bertha	A	Month 3	1 7	$2\overset{\text{Year}}{0}12$	12:10 PM			
	Exam	ıner				4b. City, Town, o		eath	4c. Cou	nty of Death	
	Funera		Hebrew Home of Gr 5. Social Security Number 6.5	eater Washi	ngton	Rockvi1			Mont	gomery	У
	Directo				yrs. last birthday)	If Under 1 Year Months Days		Hrs. 8. Date of E		9. Birth	place (State or Foreign
77	_ M		Usual Residence of Decedent	□M2\XF 97	Yrs.			1	- 1914		lon, Englan
	yland f shc ed at	햙	10a. State 10b. County	10	c. City, Town or Loc	ation		1 20 2	1717		Od. Inside City Limits
	28a-	Director	MD Montgom	ery	Rockville						1x Yes 2 No
	th the	aB	10e. Street and Number			10f. Zip Code			10g. Citizen o	of What Cour	
	rited within /2 hours after death with the Maryland al Hygiene. d other than "natural", or items 23a or 28a-f showent, the Medical Examiner must be notified at vient, the Medical Examiner must be notified at	Funeral	6121 Montrose Roa			20852			United		
10	r dea	J.F.	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13. W	as Decedent of H Yes, specify Cuba	lispanic Origin?	(Specify Yes or No		ace - Americ	
21215-0036	al", c	d by	1 Never Married 2 Married 3 Widowed 4 X Divorced	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give		Yes 2 XNo		ieπo Rican, etc.)		lack, White, e	
ŏ	hours natur ical l	Completed	15. Decedent's F	Year or Dates.					Speci	ify:	White
215	med "r	g	(Specify only highest gra Elementary/Secondary (0-12)	ide completed)	(Give ki	ent's Usual Occup nd of work done o	ation during most of v	vorking	16b. Kind of	Business/Inc	dustry
21	within giene er th			College (1-4 or 5+)	Financ	NOT use retired)					
nd	al Hy d oth	Be	17. Father's Name (First, Middle, Last)				18 Mother's I	Name (First, Middle	Fede	eral G	overnment
Maryland	z should be filed within the and Mental Hygiene. 27 is marked other tha traumatic event, the N	은	William Wolff				TO. IVIOLITE; S I	Fann			-
lar	and and is m		19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Mailing	Address (Street a	and Number or	Rural Route Numb		Micha	
2	of Health a fitem 27 i		Randie Aboud Siege	el - Daughte	r 15025	Hunter N	Mountai.	n Lane, S	er, City or Iown,	State, Zip C	ode)
ore	For Hite		20a. Method of Disposition 1 X Burial 2 Cremation 3	00	b. Place of Disposi			Date Date	20c. Location	pring	MD. 20906
ti m	tant:		4 ☐ Donation 5 ☐ Other (Specif))	Western (tory or other place		28-2012		-	,
Baltimore,	permit rays I and 2 should be fried within /2 hours after death with the Maryland death and Mental Hygiene. I mportant: If tem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service License	e Edward Sag	e1 22.1	Name and Addres			Cheshu		gland
			144	M00910	1117	0 Rockvi	ille Pil	ke. Rocks	sky-Gold	iberg Marvla	nd 20852
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only on	lications that caused the c	death. Do not enter	the mode of dying	g, such as cardi	ac or respiratory ar	rest,		Approximate
Pt	ysician/		Immediate Cause (Final disease or condition	Advanced De	ementia						Interval Between Onset and Death
TOTAL E	Medical xaminer	Н	resulting in death)	Due to (or as a cons	sequence of):					_	
. *		<u>-</u>	Sequentially list conditions,	o. 							
pe	6	ij	if any, leading to immediate cause. Enter Underlying	Due to (or as a cons	sequence of):						
ecute	a g	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Dura ta Januari							
De ey	physician the buria	call	Table 11 double Last	Due to (or as a cons	equence of):						
Box 68760 death certificate be executed	g phys as the	Completed by Physician/Medical		l							
68 certif	attending i	<u>N</u>	F FEMALE: 23b. Was decedent pregnant 2	Bc. If yes, outcome of pred	nancy						
Box death o	d for	icia	in the past 12 months? 1 Yes 2 No	1 Live Birth 2 F 4 Pregnant at time	etal death 3 E	ctopic pregnancy			1	ate of delivery	
	ache	hys	9 Unknown	9 Unknown	or death 5 🗆 O	ther (specify)			Mo	onth D	ay Year
Division of Vital Records, P.O. Hospital or Attending Physician: The law requires that the	i signed by the a Id be detached f	اج	Part II. Other significant conditions con	tributing to death but not	resulting in the unde	erlying cause give	n in Part I.	23e Did to	bacco use cont	ributo to the	and a state of the state of
Records, The law requires	been sig should b	pe									oly 4 Unknown
Sor aw re	2 she	ble						24a. Was a			
Re I	s certificate has b lirector, page 2 s	ĕ						autop	sy p	were autopsy orior to comp death?	findings available findings available of
<u>a</u>	ctor,		Was case referred to medical examiner?			26 Dies		1 🗌 Yes		1 Yes 2	□ No
of Vital	this ceral dire	<u>و</u>		spital:	☐ ER/Outpatient 3		e of Death (Che				
of of or			7. Manner of Death 1 🛣 Natural 5 🗆 Pending	28a. Date of injury (Month, Day, Year)	28b. Time of	28c. Injury a	_4 🖎 Nursing I t	ome 5 Reside	ence 6 Othe	er (Specify)	
ion	y the fu	<u> </u>	2 Accident Investigation	(Worth, Day, rear)	injury	work?	es 2 No	20d. Describe fic	w injury occurre	ea	
Division	Director: A	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, street,	factory, office		28f. Location (St	reet and Numbe	er or Rural Ro	ute Number
Dital D	eral		TT.		**			City or lown	, State)		ate Namber,
Hos	Fun	Medical	9a. Certifier 1 X Certifying Physic (Check 2 Medical Examine	an: To the best of my kno On the basis of examinati	wledge, death occu	rred at the time, o	date and place,	and due to the cau	se(s) and mann	er as stated.	
o the	To the Funeral Directory of the Funeral Direct		only one) 3 Certifying Nurse	On the basis of examination of the basis of control of the basis of control of the basis of the	f my knowledge, dea	th occurred at the	time, date and p	at the time, date an place, and due to the	d place, and due e cause(s) and m	to the cause	(s) and manner stated.
F 3	13		A TELL AM	MD		29c. License nu	umber		9d. Date signed		
		20	Nome and ad discourse	1		D695	68		3-1	7-201	2
		30). Name and address of person who com Atchutha Chilakama			121 W		1			
	State	31	. Date filed (Month, Day, Year)	A D			rose R	1., Rocky	ille, M	lary1a	nd 20852
	Registrar		MAR 21 2012	Centra &	fall						
DHMH 1	7 Rev 06-20	11		1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra AMEND#20bperFH, 3/27/12; BMW, McCo Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month MAR 20^{Year} 1:38 Ам **VERA** IRENE AUSTIN Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death WRNMMC MONTGOMERY BETHESDA 8. Date of Birth (Month, Day, Y Jan. 13, Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days Months 1 🗆 M 2 🕱 F 67 Yrs. 579-62-2022 1945 Germany Director Usual Residence of Decedent shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director Washington N/A DC 28a-f 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö Examiner must be 20011 Funeral 1345 Sheridan Street, NW 23a United States or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 ※ No Black, White, etc. þ 1 Never Married 2 Married ☐ Yes filed within 72 hours after Maryland 21215-0036 White 1 Yes 2 No Specify: If Yes, Give Specify: "natural", 3 X Widowed 4 Divorced Completed Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene.

is marked other than ' Elementary/Seconday (0-12) Federal Government College (1-4 or 5+) **2 yrs** Executive Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည George Wagner Lya \mathbf{P}_{\bullet} Braschnewitz , Ma. , and 2 should be and of Health and M. ant: If item 27 is r. r. other tr? 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zio Codel 1345 Sheridan Street, NW, Washington DC 20011 / daughter Ayorkor S. Austin altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of unk 20c. Location - City or Town, State Date Arlington Nat'l 1 Burial 2 Cremation 3 Removal from State Arlington, Virginia injury or Department of Important: If any injury or once. 3-26-2012 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McGuire Funeral Service, Inc. 21. Signature of Funeral Service Licensee 7400 Georgia Avenue, NW, Washington DC 20012 ع 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_si_i_n METASTATIC LUNG CANCER disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate Due to (or as a consequence of): the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 KNo Year Day Pregnant at time of death Yes 1 ☐ Yes ∠ ☐ 9 ☐ Unknown be detached Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performed certificate 2 No Yes 2 X No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 **X**Vo ၉ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 5 \square Pending Natural 2 🖵 No 1 🗌 Yes Accident
Suicide Investigation mpleted filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \square Homicide determined Medical 29a. Certifier X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOHNNY A. DIAS, DO

MAR 1 5 2012

31. Date filed (Month, Day, Year)

0102202781

WRNMMC, BETHESDA, MD 20889 5600

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State 1:20 AMEND#20 errMD, 3/21/12; BMW, MoCo Certificate of Death Reg. No. 2. Date of Death 06 . Decedent's Name (First, Middle, Last, 3. Time of Death 73- 2012 Physician/ 2:20 March Aileen Devine Arnold Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Carroll Hampstead Golden Crest Assisted Living Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Social Security Number **Funeral** Hours 92 Yrs. Director 192-01-0462 1 □ M 2 □ **X**F June 1, 1919 Pennsylvania Usual Residence of Decede 10d. Inside City Limits 28a-f show 10b. County 10c. City, Town or Location 10a. State the Maryland Director 1 Yes 2 No Examiner must be notified Hampstead MD Carroll 10f. Zip Code 10g Citizen of What Country? 10e. Street and Number 5 Funeral 23a USA within 72 hours after death with 21074 1811 Albert Rill Rd items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Never Married 2 Married þ "natural", or Specify: White Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify. 3 ★Widowed 4 □ Divorced If Yes, Give Year or Dates Completed Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) John Hopkins Applied I Hygiene. other than " College (1-4 or 5+) Elementary/Secondary (0-12) Secretary Physics Lab should be filed with and Mental Hygien Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ဂ Catherine Becker Theodore Albert Devine 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2516 Braddock Road, Mount Airy, MD 21771 Page 1 and 2 sh ment of Health a Wilma Davis, Friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3X Removal from State July 3,2012 ò Arlington, VA Department of Important: If any injury or Donation 5 Other (Specify) Arlington National 22. Name and Address of Facility Hines-Rinaldi Funeral Home 20904 21. Signature of Funeral Service Licensee 11800 New Hampshire Ave., Silver Spring, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): the burial attending physician Physician/Medical certificate be P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Por Day Pregnant at time of death be detached g Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, plnods Completed 24b. Were autopsy findings available 24a. Was an has In the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has completely filled in by the funeral director. page 2 performed? 2 No 1 Yes 26. Place of Death (Check_only one) 25. Was case referred to medica Medical Certificate: To Be examiner?
1 \(\sum \) Yes 2 \(\sum \) No Other: 4 Nursing Home 5 Residence 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury Accident Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 06-2011

MAR 15 2012

Thomas J. Vento, 31. Date filed (Month, Day, Year)

114 Business Center Drive, Reisterstown, MD 21136

30. Name and address of pers h who completed cause of death (Item 23a) (Type, Print)

M.D.,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Sol ARON , 2012 Year March 13, Physician/ 10:42 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery Rockville Hebrew Home of Greater Washington If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Dec. 23, 1911 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F MaryTand Director 100 578-10-5595 Usual Residence of Decedent 3a or 28a-f show t be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Directo Leesburg Loudoun Virginia 1 Yes 2 X No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a United States Funeral 20176 42829 Forest Spring Drive must 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian, and 2 should be filed within 72 hours after deal Health and Montal Hygiene. Health and Markal Hygiene. Them 27 is marked other than "natural", or iter the traumatic event, the Medical Examiner: Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 ☐XNo Specify. 3 ☑ Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Liquor Store Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dora Brotman Simon Aron 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, if Health Howard Aron, Son 42829 Forest Spring Dr., Leesburg, VA permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Judean Memorial Gardens 03/20/12 Olney, MD TereninskyssHebrew Funeral Home 21. Signature of Euroral Car 254 Carroll St., NW, Washington, DC 20012 23a. Part be or the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Dementia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial director. Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death 1 Yes 2 No 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 💢 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) æ examiner? Other: 1 ☐ Yes 2 X No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes 28d. Describe how injury occurred 1 Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Farli MD D006487

Registrar DHMH 17 Rev 7/2009

State

Box 68760

Division of Vital

Montrose

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6121

Fazli, MD

MAR 16 2012

Mina

31. Date filed (Month, Day, Year)

3-14-2012

20852

MD

Rockville

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Antonia Abdal Physician/ March 2Pay 2012 ar 7:00p M Medical 4a. Facility Name (if not Institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Potomac Montgomery 10428 Heathside Way Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** Days Hours 558-81-7348 6/28/1922 Director 1 - M 2 X F Russia 89 Usual Residence of Decedent 28a-f show 10a State notified at 10c. City. Town or Location 10d. Inside City Limits Director MD Montgomery Potomac 1 Yes 2 No 9 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral 20854 10428 Heathside Way Russia items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Armed Forces? Black, White, etc. ò þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White nan "natural", If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify Completed 3 X Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) the Own Home Homemaker Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname)
Tatiana Yermalayeva Stephen Abdal 2 other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) je 1 and 2 s t of Health a If item 27 i Anna Yedgarian/Daughter 10428 Heathside Way Potomac, Md. 20854 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit, Page 1 Department of Important; If it any injury or o 1 X Burial 2 Cremation 3 Removal from State 3/23/2012 Washington, D.C. Rock Creek Cem. 4 Donation 5 Other (Specify PHTETP TO RETWALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd. Silver Spring, Md20910 21. Signature of 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each ne Immediate Cause (Final Physician/ neumonia disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): buria attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Ď Pregnant at time of death the Unknown 9 Unknown been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? by Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas page 2 autopsy perform certificate 2 🗌 No Yes 2 X No 1 Yes 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 XNo မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 X Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 \square Pending injury work? 1 ☐ Yes 2 ☐ No Investigation Accident 2 ☐ Acciden 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 - Homicide determined City or Town, State) Medical

within 24 hours after death.

To the Funeral Director: Algorophetely filled in by the fu

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one

29b. Signature and title Acertifie 29d. Date signed (Month, Day, Year) D21340

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Raymend Bass M.D. 3941 Ferrara Drive Wheaton, Md 20906

March 22,2012

State Registrar 31. Date filed (Month, Day, Year

MAR 27

Registrar's Signa 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Josefa Bach 2012 9:25 A March 11. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gambrills Anne Arundel Regency Park If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs, last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) Director 230-54-4210 89 1 M 2 XF Nov. 14,1922 Germany Yrs Usual Residence of Decede 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland **Funeral Director** must be notified MD Anne Arundel Annapolis 1 ☐ Yes 2 👿 No ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a USA 21401 Unit 406 930 Astern Way 12, Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Medical Examiner Black, White, etc P. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: Specify "natural", 3 XWidowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. other than " Elementary/Secondary (0-12) College (1-4 or 5+) the unk Medical Nurse traumatic event. Be unk 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) unk Mental marked ပ and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health 1788 Meade Court Millersville, MD 21108 Ken Hall / Friend other 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State March 14. or 1 X Burial 2 Cremation 3 Removal from State Department of Important; If any injury or Crownsville, MD 4 ☐ Donation 5 ☐ Other (Specify) MD Veterans Cemetery 2012 S nature of up ro Se 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home Severna Park, MD 21146 495 Ritchie Hwy 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each Interval Between set and Death Immediate Cause (Final Prevairian/ 6 disease or condition resulting in death) eu i Medical Due to (a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) attending physician and I for use as the burial-transi Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this continued in the contin Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 month 1 Yes 2 No Day Pregnant at time of death Unknown P.O Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ After this certificate has been signe funeral director, page 2 should be Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Certificate: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed 1 Tyes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital A sister Other: 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 other (Spe 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural (Month, Day, Year) injury 5 Pending work? 2 No 2 Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 E 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year)

April 1

State Registrar ge and address of

121

Date filed (Mo

em 23a) (Type, Print)

4 d

completed cause of death

03

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ March 17, 2012^{Year} William Anton Bragg 2:00 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert 11499 Chews Branch Road Owings Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** Country) Days 1 ፟ M 2 ☐ F Hours Min 214-42-6727 194467 Director Usual Residence of Decedent show 10d, Inside City Limits 10a. State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 ☐ Yes 2 X No MD Calvert Owings 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11499 Chews Branch Road 20736 USA 12. Was Decedent Ever in U.S. Armed Forces?

1X Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Vietnam Year or Dates. Specify:White 1 ☐ Yes 2 🕱 No "natural" Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than College (1-4 or 5+) Elementary/Seconday (0-12) Department of Health and Mental Hygiene. Important: If item 27 is marked other the any injury or other traumatic event, the I Steamfitter Steamfitter's Union Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ William W. Bragg Dorothy Best 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arlene M. Bragg/Wife 11499 Chews Branch Road, Owings, MD 20736 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State March 20, Metropolitan Crematory Alexandria, VA 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Acenses Francis Address Coritins Funeral Home Inc. 500 University Blvd. W. ,Silver Spring, MD 20901 23a. Part 1. Enter the alsease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart ailure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Lung Cancer mos. Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury attending physician and for use as the burial trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) Pregnant at time of death 1 ☐ Yes 2 ☐ Unknown been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 ☐ No 3 🔀 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed? s after death.

| Director: After this certificate 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: ျှ 1 ☐ Yes 2 🛣 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5x Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending Investigation iniury Accident the. Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined within 24 hours at To the Funeral D completed filled in Medical 29a. Certifier 🛮 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 only one)

State Registrar

10+1

31. Date filed (Month, Day, Year)

ture and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 18 per fh g929 7-16-12 vt
State of Maryland 7 Department of Health and Mental Hygiene
AMEND ITEM#18perINF G935, 1/7/2013, WS
Certificate of Death
Reg. No. 2012 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 03 Day 16 2012 8:06 pm Santiago Rider Bernal Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery Silver Spring Holy Cross Hospital Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Hours Min. 07/1254 1956 55 Efountialvador Director 214-61-6024 Usual Residence of Decedent show er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Baltimore MD Baltimore 1 🗆 Yes 2 🔀 No 10e. Street and Numbe 10f. Zin Code 10g. Citizen of What Country? Funeral 21222 El Salvador 309 German Hill Road death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc þ 1 Never Married 2 Married 72 hours after Maryland 21215-0036 1 ∰Yes 2 □ No Specify: Salvadoran Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) should be filed within 72 h and Mental Hygiene.
7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Maintenance Janitor Be 18. Mother's Name (First, Middle, Maiden Surname) Ana Francisca Funes Viuda de Bernal 17. Father's Name (First, Middle, Last) ٩ Agustin Bernal Romero 19a. Informant's Name/Relationship (Type, Print) wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code permit. Page 1 and 2 sh Department of Health ar Important; If item 27 is any injury or other trau Rosalina Portillo de Bernal|309 German Hill Rd.,Baltimore, MD 21222 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☒ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chapeltique 3/30/2012 El Salvador 21. Signature of Funeral Service Licensee 22. Name and Address of Facility W.H. Bacon Funeral Home Wanda 3447 14th St., NW Washington, DC 20010 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Acute Myocardial Infarction disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Chronic Renal Failure Sequentially list conditions, cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence or): 1 Tansit Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of). attending physician a Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Pregnant at time of death Month Dav Year 2 🗆 No detached 9 Unknown Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛭 Unknown 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page performe Yes 2 X No 1 Yes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner's Other: 4 Hospital မ 1 Yes 2 🔀 No 1 ☐ Inpatient 2 🗷 ER/Outpatient 3 ☐ DOA □ Nursing Home 5 □ Residence 6 □ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of After 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 X Natural 5 Pending within 24 hours after death.

To the Funeral Director: Algorithms of the formulation of t Accident 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in the position, detail occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number D67355 03/19/2012

DHMH 17 Rev 7/2009

State

Registrar

Danielle Sherk 1500 Forest Glen Road Silver Spring, MD 20910-1484

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

MAR 22 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March Pearl Bloom 2012 8:40 pm Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Montgomery Hebrew Home of Greater Washington Rockville 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Min. May 27 104 Hungary **Director** 129-03-3455 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature" any injury or other traumatic events. 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director Chevy Chase 1 Yes 2 X No Maryland Montaomeru 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20815 U.S.A. 7720 Rocton Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 X No Black White, etc. þ 1 Never Married 2 Married 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify White Completed 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home 12 Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Maria Gross Samuel Singer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7720 Rocton Avenue, Chevy Chase, Maryland 20815 Marylin Schwartz - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c, Location - City or Town, State 1 🙀 Burial 2 □ Cremation 3 🛣 Removal from State King David Mem. Grdns: 03/16/2012 | Falls Church, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the dise or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Sonly one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine rate has been signed by the attending physician and page 2 should be detached for use as the burial transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 certificate 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Investigation Could not be 1 Yes 2 No Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician; To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 March 19, Physician/ Berko BARANVSKIY 8:14 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery Bethesda Suburban Hospital 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Min. 212-49-7500 **1**X M 2 □ F Months Hours **Director** 82 Feb. 6, 1930 Ukraine Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 Yes 2 No Bethesda Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20817 United States 10250 Westlake Drive #804 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces? Black White etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 Yes 2 No Specify. If Yes, Give Year or Dates. 3 N Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72. h and Mental Hygiene. 7 is marked other than "r College (1-4 or 5+) Elementary/Secondary (0-12) Engineering Engineer permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ <u>Gerschon</u> Baranvskiv unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8204 Gainsborough Ct., W., Potomac, MD Greg Portnoy, Stepson 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) Olney, MD Judean Memorial Gardens 03/22/12 4 ☐ Donation 5 ☐ Other (Specify) 21. Ignature of Huperal Service Licensee Torchinsky serepnew Funeral Home 20012 254 Carroll St., NW, Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final 5 Oryet and Beath Physician/ Congestive Heart Failure disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner 0 Years Coronary Artery Disease Sequentially list conditions. cause (Disease or injury and 20 Years Insulin Dependent Diabetes Mellitus the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) physician s the burial 10 Years Physician/Medical Chronic Renal Disease Division of Vital Records, P.O. Box 68760 as 1 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Li Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for Pregnant at time of death 1 ☐ Yes ∠ ☐ Unknown q Unknown signed by Part II. Other significant conditions contributing to death but not resulting In the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Chronic Anemia 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has le 2 page performed? Yes 2 X No certificate 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 **□X**No 1 🗌 Yes ျှ 1 Inpatient 2 I ER/Outpatient 3 XDOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of within 24 hours after death.

To the Funeral Director: After to monoletely filled in by the funer Certificate: 28c. Injury at 28d. Describe how injury occurred injury 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

State Registrar

MAR 22 2012

31. Date filed (Month, Day, Year)

29b. Signature and title

denan 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

D 0046734

29d. Date signed (Month, Day, Year) March 21, 2012

20814

			Plea									_	ible.		
		For State		State of	Marylar		artment of		and N	/lental Hy	gien	ne o c	110	10	010
		Registrar 1. Decedent's Name	o /First Middle	a Lacti		Ce	rtificate of	Death			Reg. No. 2				
Physicia			rosnan	. ,						2. Date of De Month	atn ງງ	Day	Year		
Medic Examir				, give street and numb	per)		4b. City, Town, o	or Location of	of Death	March				11.23	P
E AGIIII		Montgome	ry Hos	pice-Casey	Rockvi							ery			
Funeral		5. Social Security N	umber		Age (In yrs.		If Under 1 Year Months Days		24 Hrs. Min.	8. Date of Bir		r)			Foreign
Director		229-44-1 Usual Residence		1 🖾 M 2 🗆 F	74	Yrs.				, ,			000		
and show	ō	10a. State	10b. County		10c. Ci	ty, Town or L	ocation			F-F	· ,		1		y Limits
Maryla 28a-f ptifiec	Funeral Director	MD	Mo	ontgomery		Kensi	ngton							1 🗌 Yes	2 🛭 No
a or s		10e. Street and Nun					10f. Zip Code				10g.			ntry?	
th with ms 23 must	ner	B408 Ander	rson Ro				20895					USA			
r dear	by Fur	11. Marital Status 1 ☐ Never Marr	ied 21/2 Mar	12. Was Deced	ces?	S. 13.	Was Decedent of H If Yes, specify Cub	D							
safte ral", c Exan	q p	3 Widowed		If Van Chun			1 ☐ Yes 2 No		Specify:	White	3				
hour natu dical	To Be Completed	/Sne		nt's Education est grade completed)			edent's Usual Occu		t of work	ina	16b.	. Kind of Bu	usiness/In	dustry	
hin 72 ne. than '		Elementary/Seco		College (1-4		life. i	. 1								
ed wit Hygie other i		17. Father's Name (i	First Middle		5+	Те	acher	10 Made	aula Niana	+ (First Adistrile					
be filk ental I ked c c eve		Joseph		, i						e (First, ivildale, • Watsor		en Surname,	"		
nould nd Me s mar		19a. Informant's Na				19b. Mai	ing Address (Street					or Town. Si	tate. Zip (Code)	
d2sk alth a n 27ik ertran		Joyce 1	Burlas	/Wife										/	
of He of He fitem		20a. Method of Disp		3 Removal from S	20b. I	Place of Disp	osition (Name of matory or other pla	cel		Date	20c.	Location -	City or To	own, State	
Page ment ant: I		4 Donation			raic		Heaven Ce		y Y	arch 26 2012	Si	lver :	Spri	ng, MD	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. The many injury or other traumatic event, the Medical Examiner must be notified at anone.		21. Signature of Fur		Licensee		É	2. Name and Addre	ess of Facilit	ins	Funera	1 H	ome I:	nc.		
0 5 5 0	_		Max.	• •/\								ver S	prin		
		23a. Part 1. Enter t shock, or hear Immediate Cause (rt failure.List	complications that ca only one cause on eac	h line.	th. Do not en	ter the mode of dyll	ng, such as	cardiac (or respiratory an	rest,			Interval Betw	reen
hysician/ Medical		disease or condition resulting in death)		a. Gallb	ladder r as a conseq		r						_	Onoct and D	-
Examiner				Due to (o	r as a conseq	derice oi).									
	ner	Sequentially list co if any, leading to im	nmediate	b. Due to (o	r as a conseq										
ian and unia-transit	Examine	cause. Enter Under Cause (Disease or that initiated events													
e execution are an area area area area area area a															
death certificate be ne attending physic ed for use as the bu	Physician/Medical												-		
ding p	/Me	IF FEMALE:		23c. If yes, outco	ome of pregna	ancv									
atten atten I for u	ciar	23b. Was decedent in the past 12 r 1 Yes 2	Ectopic pregnan Other (specify)	су							ear				
ne de ry the ached	hysi	g Unknown	□ NO	4 ☐ Pregna 9 ☐ Unkno											
res that the death certificate be signed by the attending physici d be detached for use as the bu	by P	Part II. Other signif	icant conditie	ons contributing to dea	ath but not res	sulting in the	underlying cause g	iven in Part	l.	23e. Did to	obacco	o use contri	ibute to th	ne cause of de	ath?
requires been sign should be	ted									1 🗆	Yes	2 K No	3 Pro	bably 4 🗆 U	nknown
aw re as be 2 sh	Completed									24a. Was autor	osy	р	Vere auto	psy findings av	/ailable use of
rne i zate h page	Con									perfo 1 ☐ Yes	rmed? 2 🔀	No 1		2 🗆 No	
ysician: The law is certificate has the director, page 2 s	Be	25. Was case referre examiner?		Hospital:			26. F	lace of Deal	th (Check	k only one)		Ho	spic	<u>e</u>	
rnys this or	: To	1 Yes 2 2 27. Manner of Death	X No	1 ☐ 1r 28a. Date of		ER/Outpatie	ent 3 🗆 DOA	4 ∐ Nu				6 XOthe	r (Specify		
th. th. After e fune	Certificate:	1 ☒ Natural 2 ☐ Accident	5 Pendir	ng (Month	, Day, Year)	Injury	wor			zed. Describe ii	IOW IIIJ	ury occurre	ru		
After er dea ector by the	artifi	3 Suicide 4 Homicide	6 Could	not be 28e. Place o			reet, factory, office		-	28f. Location (S			r or Rural	Route Numbe	er,
ral or		1 E Homesa	dovom	building	g, etc. (Specif)	/)				City or Tow	vn, Sta	te)			
fospir 4 hour uner: ely fill	Medical	29a. Certifier 1 (Check 2		Physician: To the best examiner: On the basis											ner stated
in the Hospital of Attending Physician: The law within 24 hours after death. To the Euneral Director: After this certificate has to the Euneral Director: After this certificate has to the formpletely filled in by the funeral director, page 2 s	Me	only one) 3	Certifying	Nurse Practitioner:			e, death occurred at	the time, dat			he cau	se(s) and m	anner as	stated.	nor otatou.
		29b. Signature and	Tie of certifier	Miles		2.1.0	29c. Licens	43201			29d. E	ate signed	(Month, i	Day, Year)	
1.5		30 Norma are discisle	YULL	/MUZ	of death (the	<np< th=""><th></th><th>-JZUI</th><th></th><th></th><th></th><th>1/20</th><th>1/2</th><th></th><th></th></np<>		-JZUI				1/20	1/2		
		Debrah M:		who completed cause CRNP			Drive, I	Rockvi	11e.	MD 208	350	-			
Stat	e.	31. Date filed (Monti	h, Day, Year)	₿ 2. Reg	gistrar's Signa			-							
Registra	ar	MAC	262	117 12.	A . d.	100	1								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 9, Day 2012 Year Physician/ 12:10 P M CAROL E. BARQUIST Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Rockville Montgomery Casey House -Montgomery Hospice If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) Days Hours 472-14-4388 **Director** 1 M 2 X F 89 Dec. 21,1922 Minnesota Usual Residence of Decedent 23a or 28a-f show ast be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 ☐ No Maryland | Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be anoine. Funeral 333 Russell Ave. #214 20877 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 X No Black, White, etc. þ 1 Never Married 2 Married ☐ Yes Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: White 3 X Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Journalist Magazine Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ,0 Anna Dorn Emil Aichele 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2018 Rittenhouse Square Philadelphia, PA 19103 David L. Barquist (Son) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) March 10, 1 Burial 2 T Cremation 3 Removal from State Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crem. 2012 Signature of Funeral Service Li 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Dr. Gaithersburg, MD 20877 (M01116)23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Phyniciani Metastatic Ovarian Cancer disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine Due to (or as a consequence of) if any, leading to immediate To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial dispersion. Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 X No g 🗌 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Failure to Thrive Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 😾 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 🗌 Yes Yes 2 X No Be 25. Was case referred to medica 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 4 Nursing Home 5 Residence 6 Dother (Specify) Hospice 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury 1 X Natural 5 Pending work? 1 Yes 2 No Accident Investigation ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number March 9, 2012 D0060634 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6001 Muncaster Mill Rd. Rockville, MD 20855 Bindu C. Joseph M.D.

State

Registrar

31. Date filed (Month, Day, Year)

MAR 14 2012

82. Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MARCH THURSTON HARRISON BOYD 8:45P Medical 4a. Facility Name (if not institution, give street and number) 4b. City Town or Location of Death 4c. County of Death Examiner NATIONAL INSTITUTES OF HEALTH BETHESDA MONTGOMERY 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Days Hours O2" 22 / 1952 1 X M 2 D F 216-60-3946 60 Texas Usual Residence of Decedent 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location Director 1 🗌 Yes 2 🗓 No Columbia Maryland Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21044 U.S.A. 11670 Little Patuxent Parkway 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black White etc. 1 Never Married 2 Married Completed by 1 Yes 2 X No Specify: Specify: Black 3 Widowed 4 X Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Automotive Technician Small Engine Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Dorothy Marie Harrison Braxton Julian Boyd, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4425 Valley Brook Lane, College Park, Georgia 30349 Kaaren Cranford - Sister 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 D Burial 2 X Cremation 3 D Removal from State Lincoln Crematory 03/20/2012 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service License 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death disease or condition resulting in death) Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that initiated events Due to (or as a consequence of): resulting in death) Last ledical

B To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial the completed filled in by the funeral director, page 2 should be detached for use as the burial the completed filled in by the funeral director, page 2 should be detached for use as the burial the completed filled in by the funeral director, page 2 should be detached for use as the burial the completed filled in by the funeral director, page 2 should be detached for use as the burial the completed filled in by the funeral director, page 2 should be detached for use as the burial than the completed filled in by the funeral director, page 2 should be detached for use as the burial than the completed filled in by the funeral director, page 3 should be detached for use as the burial than the funeral director and the funeral d Division of Vital Records, P.O. Box 68760

Funeral

Director

or 28a-f shov

ral", or items 23a or 28a-f sho Examiner must be notified at

"natural",

and Mental Hygiene.

. Page 1 and 2 should be file iment of Health and Mental I tant: If item 27 is marked o

the Medical

traumatic event,

Department of H Important: If ite any injury or ot once.

Physician/

Medical Examiner

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

ysician/iv	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No g ☐ Unknown	23c. If yes, outcome of pregnancy 1	23d. Date of delivery Month Day Year			
ed by Fr	Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown			
Complet		24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No				
0	25. Was case referred to medical examiner?	26. Place of Death (Check on	nly one)			
2	1 ☐ Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DCA Other: 4 Nursing Home	e 5 Residence 6 Cther (Specify)			
Care	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident Investigati	(Month, Day, Year) injury work? on M 1 ☐ Yes 2 ☐ No	d. Describe how injury occurred			
Teo I	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homlcide determine		ocation (Street and Number or Rural Route Number, City or Town, State)			
nealca	(Check 2 Medical Example (Check 2 Medical Example)	ysician: To the best of my knowledge, death occurred at the time, date and place, and d niner: On the basis of examination and/or investigation, in my opinion, death occurred at the tires Practioner: To the best of my knowledge, death occurred at the time, date and place, a	e time, date and place, and due to the cause(s) and manner stated.			

0101243619

29d. Date signed (Month, Day, Year)

10 CENTER DRIVE, BETHESDA, MARYLAND 20892

DHMH 17 Rev 7/2009

Registrar

only one) 29b. Signature

31. Date filed (Month, Day, Year)

ROJELIO MEJIA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death Physician/ Day Lucile Shapiro Bendick Medical March 9:00A 4a. Facility Name (if not institution, give street and number) Examiner 4h. City. Town, or Location of Death 4c. County of Death Brighton Gardens Assisted Livina Chevy Chase Montgomery Social Security Number Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Months (Month, Day, Year) Hours Min. 134-09-0868 Director 1 🗆 M 2 🗓 F 99 12/24/1912 Connecticut Usual Residence of Decedent or 28a-f show notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits by Funeral Director Chevy Chase 1 Yes 2 X No Maryland Montgomery 10e. Street and Number 10f. Zip Code ò ms 23a or must be r 10g, Citizen of What Country? 5555 Friendship Blvd. 20815 u.s.A. items 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Examiner Black, White, etc 5 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", Specify. Completed 3 X Widowed 4 Divorced White Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 all Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the High School English Teacher Education alth and Mental Hygie 27 is marked other r traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Charles Shapiro Stella Rosan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Marc Bendick, Jr. - Son 4411 Westover Place, NW, Washington, DC 20016 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or o once. ŏ ☐ Burial 2 🗶 Cremation 3 ☐ Removal from State Lincoln Crematory 03/16/2012 | Brentwood, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring,MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Onset and Death Month Immediate Cause (Final Physician/ Inanition disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Parkinson's Disease Years Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) burialtraesit death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Box 68760 the as IF FEMALE: JSe 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ò in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 2 the 9 Unknown P.O. I ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown certificate has been si irector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director: After this certificate h 1 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Assisted Hospital Other: 1 Yes 2 X No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) filled in by the funeral Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completely Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29d. Date signed (Month, Day, Year)

State Registrar

30. Name and address of person

Lila McConnel, M.D.,

ause of death (Item 23a) (Type, Print)

82. Registrar's Signature

D39456

5530 Wisconsin Avenue, #1445, Chevy Chase, Maryland 20815

March 14, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 03/13/2012 WILBUR A. BELITON, SR. 6:00 A M Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Kensington Nursing & Rehabilitation Kensington Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Funeral 8. Date of Birth Director 01/19/1923 250-32-2584 89 Usual Residence of Decedent 28a-f shov the Maryland 10c. City, Town or Location 10d. Inside City Limits Director notified MD 1X Yes 2 ☐ No Prince George's Brandywine 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? pe ms 23a must be Funeral with 12100 Elmwood Drive 20613 USA Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian Examiner X Yes 2 No 1943-Yes, Give ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural". 3X Widowed 4 □ Divorced Completed Specify: Black Year or Dates 1946 the Medical 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) ed other than 'event, the Me United States Elementary/Seconday (0-12) College (1-4 or 5+) Mail Handler Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H f item 27 is marked of r other traumatic ever မ Matthew Belton, Sr. Marietta Canty 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Gloria Belton/Daughter 12100 Elmwood Drive, Brandywine, MD 20613 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Cheltenham Vet. Cem. 03/26/2012 Cheltenham, MD Signatur Funeral Service icensee 22. Name and Address of Facility Snowden Funeral Home 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Failure to thrive due to end-stage Parkinson's disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Disease Sequentially list conditions, in any, reading to immediate cause. Enter Underlying Due to (or as a consequence on). ending physician and r use as the burial trapsit Cause (Disease or iinjury Dementia that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be P.O. Box 68760 IF FEMALE for use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) atte in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death Unknown signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, End-stage Parkinson's Disease 1 ☐ Yes 2 🛛 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe certificate 2X No Yes 2 XNo 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 🗶 No Other: ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 4 X Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28b. Time of 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28d. Describe how injury occurred Natural
Accider
Suicide 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. of person who completed cause of death (Item 23a) (Type, Print

State Registrar filed (Month, Day,

AVE

3000

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State	of Maryla	and / Dep	artmen			and M		do a			
			Registrar 1. Decedent's Name (First, Middle	a, Last)			rincai	e or i	Jeani		2. Date of Dea		11-2-	3. Time of Death	
	Physicia			Theora	Owen B	Barnett					March	13	2012	8:50а м	
	/Medio		4a. Facility Name (If not institution	, give street and n	ım <i>ber)</i>		4b. City,	Town, or	Location o	f Death		4c. Co	unty of Death		
		· .	Lorien Nursing						umbia				Hou		
	Funeral		5. Social Security Number 332-24-2988	6. Sex 1 ☐ M 2 💢 F		rs. last birthday, 7 Yrs.	If Under Months	Days	Hours 1	Min.	8. Date of Birth (Month, Day	n v, Year)	9. Birthp Cour	place (State or Foreign http) The Carolina	
#/	Director		Usual Residence of Decedent								01/29	7/1925	Non	n catalina	
	rylanc how		10a. State 10b. County		10c.	City, Town or L	ocation		_				1	10d. Inside City Limits	
	h the Maryland r 28a-f ehow r notified at	Directo		Howard					lumbi	ia				1 ☐ Yes 2 🕅 No	
3	with the	Dire	10e. Street and Number	Daturont	Darbus		10f. Zip	Code	2104	1 1		10g. Citizen	of What Coul	S.A.	
	seeth ms 23	Funeral	11440 Little	12. Was De	edent Ever in	-	Was Deced	dent of H			acify Yes or No- Rican, etc.)	14.	Race - Ameni	can Indian,	
٥	ours after deeth with rat, or Items 23a or Examiner must be	Fur	1 Never Married 2 Marr	ied 1 ☐ Yes If Yes, G	2 🔀 No		If Yes, spec		in, Mexican Specify:	i, Puerto	Rican, etc.)	A	Black, White, STUCAN-	-American	
5-0036	hours after deeth with the Maryland turet, or teems 23a or 28a-f ehow at Examiner must be notified at	d by	3 ☐ Widowed 4 ሺ Divorced	Year or	Dates:										
7	in 72 ho "natur	olete	(Specify only highes			16a. Dece (Give	dent's Usua kind of woi DO NOT us	al Occupa rk done d se retired	ation during most f)	t of worki	ng	16b. Kind (of Business/In	dustry	
717	filed within 72 Hygiene. Ither than "na int, ine Medic	Completed	Elementary/Secondary (0-12)	College	(1-4or 5+)			Cle				Wood	lward &	Lothrop	
and	al Hygi d other	Be C	17. Father's Name (First, Middle,	Last)					18. Mothe	r's Name	(First, Middle,		,		
<u>V</u>	ould b Ment Ment arkec	To	vesper woody Ella Chapple												
Z Z	s 1 and 2 should f Health and Mer fem 27 is marke other traumatic		19a. Informant's Name/Relations Shelly Barnett		ton	1								MD 21044	
	Healt Healt tem 2		20a. Method of Disposition	- vaagn		b. Place of Disp cemetery, cre					Pate ate		ion - City or T		
ē			1 XBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		State	cemerery, cre Urklawn				3/17	1/2012	Rocky	illo_	Maryland	
baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service		19151									Home, Inc.	
מ	88 5 8		Kalnura	Init	W T	11	800 N	lew t	lampsh	ire	Ave., Si	ilver		, MD 20904	
			23a. Part1. Enter the disease, or shock, or heart failure. List	only one cause on	each line.									Approximate Interval Between Onset and Death	
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	HCRA	•	F F 1	0 06	7	~~~	MO N.	<u>α</u>			
	Examiner			Due to	o (or as a cons	sequence of):									
	_	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of):												
	and and	Examin													
/60,	death certificate be executed e attending physicien and of for use as the buil termelt	cal E													
289	ificate g phys			0.											
gog	leath certific attending pl	Physician/Med	IF FEMALE: 23b. Was decedent pregnant		utcome of pre		⊒Ectopic pr	regnancy	,			23d	23d. Date of delivery		
		sicia	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		nant at time		Other (sp						Month	Day Year	
л О	law requires that the as been signed by th 2 should be detache	Ph)	Part II. Other significant condition	ons contributing to	death but not	resulting in the	underlying c	ause giv	en in Part I.	,	23e. Did to	obacco use	contribute to	the cause of death?	
Hecords,	juires that n signed b	d by	endstag	E Dem		AC		by	19.	<u> </u>	101	/es 2□N	lo 3□Pro	bably 4 Dunknown	
<u>ဂ</u>	aw requir s been si 2 shoułd I	Completed		2							24a. Was		4b. Were aut	opsy findings available omptetion of cause of	
	The ate h page	EOC									autop perfo	rmed?/	death? 1 ☐ Yes	2□ No	
Vital	Physician: Th this certificate ral director, pag	Be (25. Was case referred to medica examiner?					104		o Death	Check only o	ne)			
5	Phys this aldii	٠ <u>۲</u>	1 ☐ Yes 2 ♠ No 27. Mann of Death			2 ER/Outpatie			4 3 30		me 5 Resid			fy)	
o	ding I th. After funer	tlon	1 Vatural 5 Pendir		of Injury nth, Day Year	r) Injury	M	28c. Injun Wor	k? Yes 2⊡I		200. 50001100 .	,ou,ary o	303.103		
DIVISION	al or Attendi after death. I Director: A d in by the fu	Certification;	3 Suicide 6 Could 4 Homicide determ	not be 28e. Plac	e of Injury - A	At home, farm, s	treet, factory	y, office			28f. Location (5 City or Tox		lumber or Rur	al Route Number,	
5	ital or irs afte rel Dir ted in	Cert	- Chieffield	001	unig, 8tc. (<i>D</i>)			A-111							
	To the Hospital or Attending within 24 hours after death. To the Funerel Director: After Completely filled in by the fune	Medical	29a. Certifier 1 Certifyir (Check only one)	ng Physician: To the Examiner: On the and ma	ne best of my basis of exam	knowledge, dea nnation and/or i	th occurred ovestigation	at the tir , in my o	ne, date an pinion, dea	id place ith occur	and due to the od at the time,	cause(s) an date and pla	d manner as a	stated. to the cause(s)	
	within 2 To the Complet	Med	29b. Signature and little of certifie	•	TITIOT STATEG.	1013	-		e number	. 6 ,			igned (Month		
	5		· Cool	- The	- C	KN1	K	11-	1175	2		3/1	3/21	12	
			30. Name and address of person	who completed car	of death (Item 23a) (Type	, Print)	۱. ۸		C1-	se 4	1105	- 2	1204	
			31. Date (ijed (Month, Day, Year)		Registrar's Si		ar C	NUI		54	175	۵ مرا			
	Sta Registr		BAD 1 A 2	012	ingistral's S	1 be	del.								

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 24 Pay 2012^{Ye} 5:10 PM March James Raymond Bergmann Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Medstar Montgomery Medical Center 01ney Montgomery Social Security Number 6. Sex **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Hours 577-46-0674 **Director** 1 M 2 🗆 F 75 14, 1936 Washington, DC Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits must be notified at Director MD Montgomery Silver Spring 1 Yes 2X No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 3836 Glen Eagles Drive 20906 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian þ Black, White, etc. 1 Never Married 2 Married Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White "natural" Completed 3 Widowed 4 Divorced Year or Dates. 1955-57 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) CPA Accounting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental ! marked ည Page 1 and 2 should be Everett Bergmann Anna_Mae Meany is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health. tem 27 Barbara J. Bergmann/Wife 3836 Glen Eagles Drive, Silver Spring, MD 20906 tem 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot
once, cemetery, crematory or other place) March 28 1 🔀 Burial 2 🗆 Cremation 3 🗖 Removal from State Gate of Heaven Cemetery 4 Donation 5 Other (Specify) Silver Spring, MD 2012 21. Signature of Funeral Septice Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd. W, Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ SEPTIC SHOCK disease or condition Medical resulting in death) Examiner PERFORATION ABDONINAL Sequentially list conditions, it any, reading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events COLITIS and Due to (or as a consequence of) resulting in death) Last use as the buria attending physician Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ Live Birth 2 L retail Co.

Pregnant at time of death in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 1 Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ of Vital Records Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗵 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No Yes 2X No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🔀 No Other: မ 1 🔀 Inpatient 2 🗌 ER/Outpatient 3 🗌 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 🗓 Natural 5 Pending injury 2 Accident
3 Suicide Investigation M 1 Tes 2 No Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined 29a. Certifier 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie

Registrar

DHMH 17 Rev 06-2011

MAR 27

5+l

D72505

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Laura Mae Burrell Physician/ March 13 2012 2:55 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3455 Raleigh Court White Plains 8. Date of Birth
(Month, Day, Year) Charles Social Security Number If Under 1 Year If Under 24 Hrs. . Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Country) VA Hours 1 □ M 2 🔀 F Director 87 1924 231 26 2323 28a-f show 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location must be notified at 10d. Inside City Limits Directo 1 Yes 2 No Charles White Plains ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 3455 Raleigh Court 20695 Charles 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Medical Examiner o, 9 1 Never Married 2 Married ☐ Yes 2☐ No Yes, Give Maryland 21215-0036 1 Yes 2x No Specify. "natural", 3 X Widowed 4 Divorced Specify: Black Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the Homemaker Own Home permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any Injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Powell Luceal McMillian 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3455 Raleigh Court WhitePlains, MD 20695 Brenda Burrell / Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Calvary Cemetery Norfolk, VA 3/19/2012 Signature of Funeral Service License 22. Name and Address of Facility Metroplitan Funeral Service 120 W. Berkley Ave. Norfolk, VA 23523 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ence disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Due to (or as a consequence of) burial-tran Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical certificate be Box 68760 as the k IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months? Day Year 4 Pregnant 9 Unknown Pregnant at time of death signed by the a Yes 2 No 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, the Hospital or Attending Physician; The law requires Completed 1 Yes 2 No 3 Probably 4 hknown been 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy within 24 hours after death.

To the Funeral Director. After this certificate Yes filled in by the funeral director, To Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural 1 Yes 2 🗆 No Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier 1-Gretifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. сопретер Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) a 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year) MAR 16

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			_ FOI	State of Maryland / Dep	partment of Health and N	Mental Hygiene	010 10057
			State Registrar	Ce	ertificate of Death	Reg. No.	16001 710
	Physicia	n/	Decedent's Name (First, Middle, Last)	Q 1.		2. Date of Death Month Day	3. Time of Death
	Medic	al		ee Beverle	<u>Y</u>	March 11	2012 12:46 PM
1	Examin	er	4a. Facility Name (if not institution, give str		4b. City, Town, or Location of Death	1 .	unty of Death
and the	Funeral		5. Social Security Number 6. Sex	Tospi Tal	If Under 1 Year If Under 24 Hrs.	R. Date of Birth	9. Birthplace (State or Foreign
	Funeral Director			M2 F Oil Yrs.	Months Days Hours Min.	(Month, Day, Year)	Country)
	MO		Usual Residence of Decedent	87		Nov. 26, 1927	1 Conneticut
	yland f s hc ed at	cto	10a. State 10b. County	10c. City, Town or L	ocation		10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	e Mar 28a notifi	je	10e. Street and Number	eorge King	George_	100	
	ith th	la l	- 1	1 :0	22485	Jog. Citizen	of What Country?
	ath w	Funeral Director	15037 Jordan	2. Was Decedent Ever in U.S. 13	. Was Decedent of Hispanic Origin? (Spo	ecify Yes or No-	Race - American Indian,
9	er de or ite mine	by F	1 Never Married 2 Married	Armed Forces? 1 Xyes 2 No If Yes, Give	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, etc.
21215-0036	72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho fedical Examiner must be notified at	ted	3 Widowed 4 Divorced	If Yes, Give Year or Dates.	1 Yes 2 No Specify:	Spe	city: Black
2-(2 hot "nate	Completed	15. Decedent's Educ (Specify only highest grade	completed) (Giv	edent's Usual Occupation e kind of work done during most of work	ing 16b. Kind o	of Business/Industry
121	within 7 giene. er than , the Ma	mo.	Elementary/Secondary (0-12)	College (1-4 or 5+)	DO NOT use retired)	City	of Baltimore
	filed wi al Hygie d other event, tl	a)	17. Father's Name (First, Middle, Last)	110		e (First, Middle, Maiden Surn	
an	be fill ental rked c	1º	Moses Bev	erly	Engr	0	· ·
Maryland	should and M is mai		19a. Informant's Name/Relationship (Type		iling Address (Street and Number or Run		
	id 2 s ealth a n 27 i er tra		Togn Beverly,	vite 150	37 Jordan Ln.	King George	Va. 22485
ore	of He		20a. Method of Disposition 1 Burial 2 Cremation 3 Re	emoval from State 20b. Place of Dispersion 20b.	oosition (Name of ematory or other place)	Date 20c. Locati	on - City or Town, State
<u>H</u>	. Pag tment tant: Jury o		4 ☐ Donation 5 ☐ Other (Specify)	Little A	rk Cemetery 3/1	7/2012 King	George, Va.
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Mayland Department of Health and Mentall Hygiene. Important: If tiem Z'i is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee		22. Name and Address of acility	229401	Washington
	20 = 6 O		23a. Part 1. Enter the disease, or complic	ations that caused the death. Do not el	Trisce lonic h, ff		Md, 20601
١.,	and the same of th		shock, or heart failure. List only one	cause on each line.		or respiratory arrest,	Interval Between Onset and Death
E	Medical		disease or condition resulting in death)	Due to (or as a consequence of):	NOROME		
The state of the s	Examiner			INFECTIOUS	ENCEDHALAPAT	HY	
-	-	ner	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of).			2
	uted od ransit	ami	cause. Enter Underlying Cause (Disease or injury that initiated events	CHMONIC KIDN	EY DIZEASE		
	ate be executed hysician and the burial-transit	dical Examiner	resulting in death) Last	Due to (or as a consequence of):			
09	ate be ohysic the b	dic	d				
687	ertifica ding p	/Me	IF FEMALE:	c. If yes, outcome of pregnancy		224	L Date of delivery
Вох	ath ce attend for us	cian	in the past 12 months?	1 Live Birth 2 Fetal death 3	Country Co		I. Date of delivery Month Day Year
m.	ires that the death certifica signed by the attending pl d be detached for use as t	Physician/Me	1 Yes 2 No 9 Unknown	g 🗌 Unknown			
P.O.	that the properties that the properties of the p	by P	Part II. Other significant conditions cont	ributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use o	contribute to the cause of death?
5	requires been sign should b	ed t		-4-		1 🗌 Yes 2 🗍 N	No 3 Probably 4 \Qunknown
Ö	law requi has been ge 2 shoul	Completed				24a. Was an 2-	4b. Were autopsy findings available prior to completion of cause of
Re	The la ate ha	Son			<u> </u>	performed?	death? 1 Yes 2 No
ta	cian: ertific ector,	Be	25. Was case referred to medical examiner?	spital:	26. Place of Death (Chec	k only one)	
Ž	Physi this c al dir	2	1 ☐ Yes 2 No 27. Manner of Death	1 Inpatient 2 ER/Outpat 28a. Date of injury 28b. Time		ome 5 Residence 6	
0	ding l h. After funer	ate	1 Natural 5 Pending	(Month, Day, Year) injury		28d. Describe how injury oc	curred
sio	Atten r deat ctor; by the	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, s			umber or Rural Route Number,
Division of Vital Records,	al or a		4 D Homicide determined	building, etc. (Specify)		City or Town, State)	
_	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transt	Medical	29a. Certifier 1 Certifying Physic	ian: To the best of my knowledge, deat	h occurred at the time, date and place, a estigation, in my opinion, death occurred a	and due to the cause(s) and not the time, date and place, and	manner as stated. d due to the cause(s) and manner stated
	the H hin 24 the Fi πplete	Me	only one) 3 Certifying Nurse	Practitioner: To the best of my knowled	ge, death occurred at the time, date and p	ace, and due to the cause(s) a	and manner as stated.
	6 7 wit		29b. Signature and title of certifier	(D)	29c. License number	-	igned (Month, Day, Year)
	6		KASHEET TRAS	4	MD 6532		CH 12TH 2012
_	pa		30 Name and address of person who cor	npleted cayse of death (Item 23a) (Type	PATTI ROAM. (CLINTON 1	MA 20735
	Stat	e	31. Date filed (Month, Day, Year)	32. Figistrar's Signature	and the		17 100
	Registra		MAR 1 5 20	16 Heren B. 1	g www.		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death . Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician/ 2012 A^{M} 1:48 March Marie Beauchamp Bryce Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Mount Airy Frederick Kline Hospice House 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign . Social Security Number **Funeral** Months Davs Hours Sep 3, 1955 Country) 468-70-9240 56 Texas Director 1 □ M 2 **X** F Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director Frederick must be notified Frederick Maryland 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? ö 10e. Street and Numbe 21703 4604 Skyline Terrace items 23a Funeral U.S.A. within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Examiner ed Forces? 1977-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ō X Yes by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: Specify: White 1984 "natural" 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Ith and Mental Hygiene. 27 is marked other than 'traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Computer Technology Computer Science-Finance 5+ Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ Mae Timmer Blackwood Donna Dr. William 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
P.O. Box 263, Braddock Heights, Maryland 21714 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau David A. Beaucamp, Husband 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Smithsburg Crematory Mar 23,2012 Smithsburg, Maryland 4 Donation 5 Other (Specify) 21. Signatur Keeney & Basford P.A. Funeral Home M00706 106 East Church St, Frederick, Maryland 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ 01 1606 disease or condition Medical resulting in death) Examiner Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate Exami The law requires that the death certificate be executed sician and burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Month Day ed by the a 9 Unknow P.O. signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Minknown Division of Vital Records, Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 certificate has 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 1 Tes 2 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury 28c. Injury at Certificate: the Hospital or Attending 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide the f Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check

3

APR v 2 2012

only one)

29b. Signature and

State Registrar who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License numbe

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 03/19/2012 8:15 A Edna Mae Bollinger /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Long View Nursing Home Manchester If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 09/12/1923 5. Social Security Number 7. Age (In yrs, last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🕱 F 219-14-7910 MD 88 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State show 1 and 2 should be filed within 72 hours after death with the Maryla Health and Mental Hygiene. It is marked other than "natural", or items 23a or 28a-f show ther traumatic event, the Markal Examiner must be notified at 1 ☐ Yes 2 X No Funeral Director MD Carroll Westminster 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 3760 Salem Bottom Road 21157 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 27 No Specify þ Specify: White 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) excavating business co-partner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဂ္ George Maynard Martz Ava Irene Keyser 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21102 1699 Harvey Yingling Road, Manchester, MD If item 27 or other t Lynda Giles/daughter Baltimore. 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or ott Deer Park Cenetery X Burial 2 ☐ Cremation 3 ☐ Removal from State 03/23/2012 Westminster, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Paritts Funeral Home and Chapel 21. Signature of Funeral Service Ligensee 412 Washington Road, Westminster, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final heart Congestine **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner argiomitoba Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the huria Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 1 ☐ Yes 2 ☐ No the detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ♠ No 24a. Was an has autopsy Physician: The certificate 1 ☐Yes 2 No : After this certification and director, I Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 24 hours after death Funeral Director: 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only within 24 the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Zoens Wieya march 21,2012 D005 1705 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 349 Malcolm Dr Westminster. MD 21157 Pansuriya MD. 3

Day Year)
MAR 3 U 2012 Register's Signature mayan 31. Date filed (Month, Day) State Registrar

3/

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death Day 2012 4b. City. Town, or Location of Death 4c. County of Death Anne Arundel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign (Month, Day, Year Feb. 22,1926 Pennsvlvania 10d. Inside City Limits 1 ☐ Yes 2 🗓 No 10g. Citizen of What Country? USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black White, etc. White 16b. Kind of Business/Industry
Department of Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Commerce 18. Mother's Name (First, Middle, Maiden Surname) Madeline Raymer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 1190 River Bay Road Annapolis, MD 21409 20c. Location - City or Town, State March 13, Baltimore, MD 2012 Barranco & Sons, P.A. Severna Park Funeral Home Severna Park, MD 21146 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or beart failure. List only one cause on each line. Approximate Interval Between et and Death 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 2 26. Place of Death (Check only one) 4 Nursing Home 5 Residence 6 Cother (Specific Files) 28d. Describe how injury occurred 1 Yes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Lertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifivao comple ed cause of death (Item 23a) Name and address of person NTA Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 2012 Physician/ Harry CHERNIKOFF March 9:00 A Medical 4b. City, Town, or Location of Death Silver Spring 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Renaissance Gardens Prince Georges If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) Social Security Number . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral Director** 137-22-9403 81 1 🗶 M 2 🗆 F Nov. 8, 1930 New Jersey Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State Director 1 Yes 2 X No Prince Georges Maryland Silver Spring 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 20904 United States 3160 Gracefield Road #1438 Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 □ No
If Yes, Give
Year or Dates Korean Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 white 1 Yes 2 X No Specify. "natural", 3 X Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working National Aeronautics & of Health and Mental Hygiene. item 27 is marked other than life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Space Administration 4 <u>Engineer</u> other traumatic event. Be 18. Mother's Name (First, Middle, Maiden Surname)
Pauline Kalchstein 17. Father's Name (First, Middle, Last) Saul Chernikoff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 210 Lastner Lane, Greenbelt, MD Keith Chernikoff, Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State Judean Memorial Gardens 03/22/12 Olney, MD 4 Donation 5 D Other (Specify) Torcamasky Hebmew Funeral liome 21. Signature of Funeral ervice Licensee 20012 254 Carroll St., NW, Washington, DC Part L. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Arteriosclerotic Cerebral Vascular Disease disease or condition resulting in death) Medical Due to (or as a consequence o Examiner 15 Years Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of and that initiated events Due to (or as a consequence of) resulting in death) Last use as the burial attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should has detached for use one the burneral Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Parkinson's Disease 1 🗆 Yes 2 🜠 No 3 🗆 Probably 4 🗆 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No Saffer deau...al Director: After this cerumos......in by the funeral director, pr 25. Was case referred to medical To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2**X** No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred iniury 5 Pending Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific

Registrar
DHMH 17 Rev 06-2011

State

10+1

Eileen Gemmell, CRNP, 3160 Gracefield Road, Silver Spring, MD

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

2 1 2012

19

20904

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 03 Physician/ 1 2 2019 2:00 pm James Alfred Carter Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth 12/16/1918 577-18-8629 1 🕱 M 2 🗆 F 93 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d, Inside City Limits Director MD Silver Spring Montgomery 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 2413 Kansas Ave. 20910 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 X No Specify: Specify: Black Completed 3 Widowed 4 Divorced Year or Dates WW - II 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Building Attendent Communications Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ William Carter Martha Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6808 Gairlock Pl. Lanham, MD 20706 Jennifer Martin-niece 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake 3/19/12 Beltsville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility W.H. Bacon Funeral Home 3447 14th St., NW Washington, DC 20010 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death neumo Due to (or as a consequence of): Sequentially list conditions, if any least scause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Norma Due to (or as a consequence of) IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
Pregnant at time of death 5 Other (specify) in the past 12 months? Month Day Year 1 Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Failure to three, 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes

Baltimore, Maryland 21215-0036 item 27 other Department of Important: If it any injury or o Physician Medical Examiner attending physician I for use as the burial Physician/Medical that the death certificate be Box 68760 the P.O. signed by þ Division of Vital Records, To the Hospital or Attending Physician: The law requires Completed Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? certificate Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: မ 1 Nipatient 2 🗆 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town. State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0071147 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

31. Date filed (Month, Day, Year)

Funeral

Director

show at

ems 23a or 28a-f sh r must be notified a

ral", or items?

"natural",

Mental Hygiene. harked other than

n and Mental I

Medical

traumatic event, the

within 72 hours after

7600 Carroll

Ave

MD

Takona Pack, ND 20912

Registrar DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

R 2 6 2012

Dereje Woreta, M.D., 12201 Plum Orchard Drive, Silver Spring, Maryland 20904

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 5 per fh, 9926 4-25-12 sm State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 22ª 20 T2 Janice Marie Cesaro 3:00 March р м Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death County of Death
Montgomery 5901 Montrose Road Apt. C1400 Rockville Social Security Number 9. Birthplace (State or Foreign Country) RI 6. Sex 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth Months March I4, 1 M 2 Dx Days Hours Min 90 039-09-7353 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2🏗 No Rockville Maryland Montgomery 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20852 USA 5901 Montrose Road Apt. C1400 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. Yes 2 No Yes, Give þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2X No Specify: "natural", 3 X Widowed 4 Divorced Specify: White Completed Year or Dates or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 7 in and Mental Hygiene. It is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Angelina Zabbo Albert Martino 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 i 5 Windward Lane, Thurmont, MD 21788 Rene S. Cesaro / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) March 24, 2012 Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia Signature of Funeral Service Licenses Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician Hypertensive Heart Disease disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sick Sinus Syndrome Sequentially list conditions, Exami B The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Congestive Heart Failure and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Atrial Fibrillation Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy death? certificate Yes 2 🛛 No 1 Yes 2 No To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☒ No Other: ္ဝ 1 Inpatient 2 ER/Outpatient 3 DOA this (4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) within 24 hours after death.

To the Funeral Director: After t 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: X Natural injury 5 Pending Accident
Suicide 1 Yes 2 No Investigation M 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 [3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) NUMBER 8 womus March 23, 2012 D47330 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas V. Joseph, MD, 50 W. Edmonston Dr. Ste. 207, Rockville, MD 20852 31. Date filed (Month, Day, Year) Registrar's Signature State MAR 26 2012 Registrar

			Plea								All Copie		_	e.		
		For State		St	ate of N	/larylar				ealth and i	Mentai Hy	giene	;			
		Registrar		1 1)			Cer	tificate	of D	eath	Т-	Reg. No	20	2	10065	
Physicia Medic		1. Decedent's Name Carlos	e (First, Middle,		erto		Cai	ntella	ı		2. Date of De Month March	ath 22	Ž, 20°	ľ 2	3. Time of Death 5:30 P M	
Examin		4a. Facility Name (if	not institution,	give street	and number)			4b. City, To	own, or L	ocation of Death	1	4c.	. County of D	eath		
/		18011 Cod 5. Social Security Nu		arden 6. Sex						If Under 24 Hrs.	Lan. (n:		Montgo			
Funeral Director		216-49-71 Usual Residence of	76	1 🔀 M			last birthday) Output Output Discretely Selected to the se		Days	Hours Min.	8. Date of Bir (Month, Da July 1		61	Counti	ace (State or Foreign Peru	
and show at	ō	10a. State	10b. County			10c. Cit	ty, Town or Loc	cation						10	d. Inside City Limits	
Maryla Ba-f	Director	Maryland	Montg	omery			German	town							1 ☐ Yes 2 🗷 No	
a or 2	JE Di	10e. Street and Num				·		10f. Zip C	Code			10g. Cit	izen of What	Count	ry?	
th with ms 23 must	Funeral	18011 Cot	tage G										United States			
r dea'	by Fu	 11. Marital Status 1 ☐ Never Marrie 	ed 2 🔽 Marri	_ A	as Decedent med Forces Yes 2	?								- American Indian, , White, etc.		
s afte ral", c Exan		If Yes, C			Yes, Give ear or Dates.	₹ NO	1	Yes 2	☐ No	Specify:	uvian		Specify: W	e		
hour "natu dical	Completed	(Spec	15. Deceden					dent's Usual				16b. K	ind of Busine			
hin 7% ne. than	mo	Elementary/Seco		Ť	ollege (1-4 or	5+)	life. DO	O NOT use r	etired)	ning most of won	Kiilig	_		_	_	
ed wit Hygie other	To Be C	17. Father's Name (F	irst Middle La	ast)	4	· · · · · · · · · · · · · · · · · · ·	<u> </u>	Remode		18. Mother's Nan	no /Eimt Middlo	•	elf Em	plo	yed	
be fill ental rked c		,	Moises		Ca	intel:	1 a			TO, MOCHELS IVALL	Rosa	Ca	ĺ			
and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f sho wither traumatic event, the Medical Examiner must be notified at		19a. Informant's Na		ip (Type, Pr				ng Address (S	Street an	nd Number or Rui				Zip Co	ode) 20874	
nd 2 s saith a n 27 i		Martha C.	Cante:	11a/S _]	ouse		1			Garden I						
e 1 ar i of He or oth		20a. Method of Disp 1 K Burial 2		3 □ Bemo	val from Stat		Place of Dispos cemetery, crem	sition (Name	of		Date		ocation - City			
t. Page tment o tant: If jury or		4 Donation	_				Souls				8/2012			n,	Maryland	
permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	-	21. Si nature of Fun	eral Service Li	censee	led	lle				of Facility De r Park I				MI	20877	
Physician/ Medical Examiner		shock, or hear Immediate Cause (F	Respiratory Failure													
uted d ansit	Examiner	Sequentially list cor if any, leading to im- cause. Enter Underl Cause (Disease or ii that initiated events	mediate lying injury		s a consequence of):											
6 5 6	<u>a</u>	resulting in death) L		L	Due to (or as	as a consequence of):										
ficate g phy as the	Jedi		- 3	u	-				-							
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the but	Completed by Physician/Medic	IF FEMALE: 23b. Was decedent print the past 12 mm 1 ☐ Yes 2 ☐ 9 ☐ Unknown	nonths?	1 4	yes, outcom ☐ Live Birth ☐ Pregnant ☐ Unknown	2 Feta at time of a	al death 3	Ectopic pre Other (spec					23d. Date of Month	d. Date of delivery Month Day Year		
es that t igned b	lby P	Part II. Other signifi	cant condition	ns contribut	ing to death	but not res	sulting in the u	nderlying ca	use give	n in Part I.					cause of death?	
requir	etec															
The law cate has be	Compl										24a. Was autor perfo 1 \subsection Yes	osy rmed?	prior t death	o com?	sy findings available upletion of cause of	
ician: sertific ector,	Be	25. Was case referre examiner?		Hospita	al.				_	e of Death (Chec	ck only one)					
Physical direction	은	1 Yes 2 X	No .		1 Inpa		ER/Outpatien 28b. Time of			4 ☐ Nursing H	ome 5 K Resid			ecify)		
tending leath. or: After the funer	Certificate:	1 X Natural 2 ☐ Accident 3 ☐ Suicide	5 Pending Investiga 6 Could n	ation	(Month, Di	ay, Year)	injury	М		es 2 No	28d. Describe h	iow injury	/ occurred			
tal or At rs after c al Direct ed in by		4 Homicide	determin		e. Place of In building, e	jury - At ho tc. (Specify	ome, farm, stre	eet, factory, c	office		28f. Location (S Cify or Tow			Rural F	Route Number,	
n 24 houner Funer pleted fill	Medical	(Check 2	Medical Ex	aminer: Or	the basis of	examinatio	n and/or investi	igation, in my	opinion,	late and place, as , death occurred a time, date and pla	at the time, date a	nd place,	and due to th	e caus	e(s) and manner stated.	
vithii To th		29b. Signature and ti		, ,	,			29c. L	icense n	number		29d. Dat	e signed (Mo.	nth, D	ay, Year)	
)		30. Name and addres	ss of person (w	hg complet	ed cause of	death (Item	23a) (Type, Pi		0716	24		Mar	ch 23,) I Z	
		Elham Bay	at, MD) Pa	Ave.,	N.W.	Washin	gtor	n, D.C.	20037					
State Registra		31. Date filed (Month	Day, Year)	2012	32 Regist	rar's Signat	1. pa	Nest.								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2 0 1 2 Esther E. Caputo 6:55a™ March Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomeru Holy Cross Hospital Silver Spring 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs **Funeral** Hours 133-09-4515 **Director** 1 M 2 X F 93 March 04,1919 New York Usual Residence of Decedent or 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits Director Silver Spring 1 Yes 2 X No Maryland Montgomery 10e. Street and Numbe 10f. Zip Code ō 10g. Citizen of What Country? rs 23a or c must b Funeral within 72 hours after death with U.S.A. 11621 New Hampshire Avenue 20904 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 [X] No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. r than "natural", the Medical Exa Specify. White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working Montgomery County Elementary/Secondary (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed with Department of Health and Mental Hygiene Important: If item 27 is marked other the any injury or other traumatic exercises. Secretary Public Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Unknown Ettinger Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10935 Pebble Run Dr., Silver Spring, Maryland 20902 Irene Lynn - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗓 Burial 2 🗆 Cremation 3 🗆 Removal from State 03/18/2012 | Rockville, Maryland Parklawn Mem. Park 4 Donation 5 Other (Specify) Funer I Sewice Lie 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 111800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. E hter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Advanced Dementia of Alzheimer's Type disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner cause. Enter Underlying Dust to (or as a nonsequence of): B The law requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 X No Month Day Year Pregnant at time of death signed by the at Id be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Pneumonia, Sepsis, Urinary Tract Infection, 1 Yes 2 No 3 Probably 4 X Unknown Completed Were autopsy findings available prior to completion of cause of Delirium, Respiratory Failure, Malnutrition, 24a. Was an autopsy performed' 1 🗌 Yes 2 🗆 No Osteoporosis 1 ☐ Yes 2 🔏 No To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be B 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **X** No 1 X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending work within 24 hours after death.

To the Funeral Director: A completely filled in by the fi 1 🗌 Yes 2 🗌 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Completely fi. 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 [Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number 29d. Date signed (Month, Day, Year) Lewalldinga D53367 March 13, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9801 Georgia Avenue, #117, Silver Spring, MD 20902 M.D., Rajan Shayamsundar, 31. Date filed (Month, Day, Year, State 1 9 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 2:19 PM ANTHONY JEROME CHISLEY Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Plato charles Medical If Unde If Under 24 Hrs 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In vrs. last birthday) Social Security Number **Funeral** Hours Min (Month, Day, Year) Country) **Director** 218-84-8963 1 **X** M 2 □ F MARYLAND MAY 16, 1960 51 Usual Residence of Decede 28a-f show 10c. City, Town or Location at 10a. State 10b. County 10d. Inside City Limits with the Maryland Director 1 🙀 Yes 2 🗌 No MARYLAND CHARLES NEWBURG 10f. Zip Code ö 10e. Street and Numbe 10g. Citizen of What Country? must be Funeral items 23a 20664 12406 CHANNEL VIEW DRIVE UNITED STATES 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Race - American Indian, Black, White, etc. Medical Examiner Armed Forces? 1 Yes 2 No 1979ò 1 Never Married 2X Married by 1 Yes 2 No Specify: Specify: BLACK "natural" 3 Widowed 4 Divorced 1988 Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working is marked other than aumatic event, the Me life. DO NOT use retired) College (1-4 or 5+) POWER COMPANY 12TH GRADE Maryland 21 SECURITY GUARD Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental မ JAMES ROBERT CHISLEY DOROTHY ANN PROCTOR CHISLEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. JAMES R. CHISLEY / FATHER P.O. BOX 215, NEWBURG, MARYLAND 20664 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) MARYLAND VETERANS CEMETERY MARCH 19, 2012 CHELTENHAM, MARYLAND 4 Donation 5 Other (Specify) Signature of Funeral Service Acense THORNTON JOHNSON MOO583 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ disease or condition crmana Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause E. Leaderlying Cause (Disease or injury that initiated events Due to (or as a consequence of). and Due to (or as a consequence of): resulting in death) Last Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 the IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b 1 Yes 2 No 3 Probably 4 Completed Inknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performe certificate 1 ☐ Yes 2 ☐ No or Attending Physician: director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other 1 Tes မ 1 🗌 Inpatient 2 🌡 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After 1 Natural 2 Accident 5 Pending work 1 🗌 Yes 2 🗌 No filled in by the Investigation
6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completely (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and titl of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		Cei	rtificate of	Death		,	Re	g. No.	UL	2 10068	
Physici		1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day								Day Ye	ear	3. Time of Death	
ledical Exam	iner	Leiby David CRockers, 51.							March 20,	2012		0713 hrs	
		4a. Facility Name (if not institution, git Meritus Medical Center	ve street and number)		ľ	4b. City, Town, Hagerstov		of Death		4c. County			
<u> </u>			17.40	o (In uso II	ast birthday)	If Under 1 Y		er 24Hrs.	le Deta of Birt	h(MM/DD/YYY	Washington M/DD/YYYY) 9. Birthplace (State or		
Funeral Director		220-70-7544	M 2 F	54	Yrs	Months D	ays Hours		Jan. 2	•	Foreign	Wash.	
Aus		Usual Residence of Decedent 10a. State 10b. County		10c. City.	Town or Locati	ion						10d. Inside City Limits	
	١.		***	•								1 X Yes 2 No	
Maryland 28a-f show 1 at once.	용	Maryland Washing	gton	па	gerstow	10f. Zip Code			10	g. Citizen of W	/hat Cour	trv?	
e Ma or 28	Director	670 771 11 1 77									,,_,	.,,	
vith the 23.8 s 23.8 e noti		673 Highland Way	7 12. Was Decedent	Ever in U.	S. 13. Wa	21740 s Decedent of		nin? (Spe	cify Yes or No-	USA 14. Rac	e - Ameri	can Indian, Black,	
death with the Maryland or items 23a or 28a-f sho must be notified at once.	Funeral	1 Never Married 2 Marrie	d Armed Forces?	X No		es, specify Cub					White, etc.		
ifter d ll", or	by Fi	3 Widowed 4 Divorce	d If Yes, Give Year or Dates:	21 140	1	Yes 2 X	No specify:			Specify:	В.	Lack	
ours a		15. Decedent's Education (Specify of		pleted)		t's Usual Occup				16b, Kind of B	usiness/Ir	ndustry	
1215-0036 I do Effed within 72 hours after Aental Hygiens amount of the transment of the transment, the Medical Examiner.	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)											
withir in the the	E C	12								Constr		on	
filed I Hyg ed oth		17. Father's Name (First, Middle, Las	•							iaiden Surnam	э)		
21215-()036 uld be filed within 72 Mental Hygiene. marked other than	o Be	Leroy David Croc 19a. Informant's Name/Relationship (Type, Print)		19b. Mailing	Address (Str	LOTT eet and Num	1e Ma	<u>ae Boyd</u> ural Route Num	ber, City or Tov	wn. State.	Zip Code)	
, MD 21215-()036 and 2 should be filed within 72 hours after death with the Maryland early is and Mental Frygiens tem 73 in marked other than "natural", or items 23a or 28a-fah traumatic event, the Medical Examiner must be notified at once	_	Paulette Crocket								, Maryl			
e, N l and Health item		20a. Method of Disposition			Place of Dispos crematory or oth	ition (Name of			Date	20c. Location			
Baltimore, MD 21 pemit. Pages 1 and 2 should Department of Health and Me Important: If item 27 is ma injury or other traumatic or		1 Burial 2 Cremation 3			se Hill		ry	Marc	2012,	Hagers	town	, Maryland	
altir nit. F sartme porta		4 Donation 5 Other Specify 21. Signature of Funeral Service Lice			22. N	ame and Addre	ess of Facility			uneral			
E P P		Rule Boar	hi		41	5 East	Wilson					aryland 21740	
Physician		23a. Part I. Enter the disease, or comfailure. List only one cause on e	plications that caused	the death.	Do not enter the	ne mode of dyir	ng, such as ca	ardiac or Card:	respiratory arre	st, shock, or he	eart	Approximate Interval Between Onset and	
/Medical Examiner	i ay	Immediate Cause (Final disease a	Disease co	ompli	cated b	y coca	ine In	toxi	cation			Death	
		or condition resulting in death)	Due to (or as a conse	equence of	f):								
	ē	Sequentially list conditions, but any, leading to immediate	Due to (or as a corrse	quence o).						- 1		
_	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a conse										
xecuted n and - transit		events resulting in death) Last	,	iquerice oi	<i>}-</i>								
3ox 68760, death certificate be executed the attending physician and I for use as the burial - trans	Medical		AMENDED 1 a	s not	ed ,23a	,27,28a	-f,pe	me,	g926 4	-16-12	sm		
760, cate be ex physiciar he burial	Med	IF FEMALE;	23c. If yes, outcom	ne of pregr	nancy					23d. Date o	f delivery		
687 ertific iding	ian/	23b. Was decedent pregnant in the past 12 months?	1 Live birth 4 Pregnant at	time of de	~~ - - - -		Ectopic Ectopic	pregnan	су	Month	D	ay Year	
Vital Records, P.O. Box 68' bysician: The law requires that the death certifi this certificate has been signed by the attending Il director, page 2 should be detached for use as 1	Physician	1 Yes 2 No 9 Unknow	1 ' -	unie or de	ath 5 Oth	ner (Specify)						:	
t the d		Part II. Other significant conditions	contributing to death	but not re	esulting in the u	nderlying cause	e given in Pa	rt I.	23e. Did tol	pacco use cont	ribute to t	he cause of death?	
P.O. res that this signed by the detac	b S								1 Yes	2 No 3	✔ Prob	ably 4 Unknown	
of Vital Records, ng Physician: The law requir the this certificate has been s meral director, page 2 should 1	Completed								24a. Was a			opsy findings available ompletion of cause of	
eco ne law te has ige 2 s	Ĕ								perform	med?	death?		
n: Ti	ပိ	25. Was case referred to medical				26.Pla	ce of Death (Check or				2	
Vita ysicis his ce direct	O D	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatier	nt 2 🗸	ER/Outpatient	3 DOA	Other ₄	Nursing	Home 5 F	Residence 6	Other:		
Of 18 P	Ë	27. Manner of Death	28a. Date of Injur (Month, Day,Ye	ry ear)	28b. Time of Ir	njury 28c. Ir	jury at Work			ow injury occur			
ion frendi leath. for: ,	atio	1 Natural 5 Pending 2 X Accident Investigat	E 2 2 20		fd 7:10	am 1	Yes 2 🗶	No	subject	used	arug		
Division tal or Attendir rs after death. al Director: A led in by the fu	Certification:	3 Suicide 6 Could not	t be 28e. Place of Inj						or Town, St	ate) 673 E	lighl	al Route Number, City and Way.	
Spital spital neral	Š	4 Homicide determine	ed (Specify)	Four	d at Re	esidenc	e		Hagerst	own, MD	•	,	
Division To the Hospital or Attendi within 24 hours after death. To the Funeral Director: completely filled in by the fi	Ca	(Chock only	cian: To the best of my er:On the basis of exam										
To t	Medical	29b. Signature and title of certifier	and manner stated.	7 1			nse number			29d. Date sign			
	=	6)-4-6)/4	a G)//	11/	3050		C.M.E.			March 21,			
		30, Name and address of person who	completed cause of de	eath (Item	23a)								
			ssistant Medical			. Baltimore	Street, Ba	altimore	e, MD 2122	3			
S	tate	31. Date filed (Month, Day, Year)	32. Registrar	's Signatu	rey								
Regis	trar	APR 0 2 2012	anoun ,	13. A	backer								

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Walter H. Douthit 0:18 A M Medical 2012 Examiner Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death b Wicomic **Funeral** If Under 24 8. Date of Birth 9. Birthplace (State or Foreign Country) NE 1**X** M 2 □ F Months 6/3/1930 **Director** 507-34-6492 Usual Residence of Decedent Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f sho. 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits Director MD Worcester Berlin 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 22 Portside Ct. 21811 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces 1 Never Married 2 Married Completed by 21215-0036 Yes 2 No 1 ☐ Yes 2X No Specify 3 Widowed 4 □ Divorced Specify: white Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Mechanical Engineer Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walter Douthit Agnes Christianson permit. Page 1 and 2 should I Department of Health and Me Important: If item 27 is marl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Heather Sneeringer/daughter 4850 Nursery Rd., Dover, PA 17315 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date 1 Durial 2 X Cremation 3 Demoval from State First State Crem. 4 Donation 5 Other (Specify) 3/15/2012 Millsboro, DE 21. Signatur of Funeral Serv 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ MAHENAN disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to lor as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month the a signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of certificate has b lirector, page 2 s autopsy death? Yes 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 1 No ပ HOSPICIZ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence After this the funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work?
1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 To the F eritifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature aj d title of certifier

BA7+1

Registrar

State

Degistrar's Signature

180-

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

MAR 16

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Buster O'Brian Dotson 2012 6:38 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 7411 Canal St. Willards Wicomico 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8 Date of Birth **Funeral** 1**X** M 2 □ F Hours (Month, Day, Year) 4/18/1943 Director 501-46-7666 68 Usual Residence of Decedent show or 28a-f shove notified at 10b. County 10c. City. Town or Location 10d. Inside City Limits Director VA Warren 1 Yes 2 XNo Front Royal 10e. Street and Number ms 23a or must be r 10g. Citizen of What Country? Funeral 141 Paw Paw Dr. USA 22630 "natural", or items edical Examiner mu Page 1 and 2 should be filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Was Decedent Ever Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Black, White, etc. ۾ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Completed 3 Widowed 4 Divorced white 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) other than Elementary/Seconday (0-12) College (1-4 or 5+) the Master Plumber Plumbing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H fitem 27 is marked ot r other traumatic ever မ Leonard Dotson Mae McNeeley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Darlene Dotson / wife 141 Paw Paw Dr., Front ROyal, VA 22630 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date <u>..</u> ₽ cemetery, crematory or other place 1 Durial 2 Cremation 3 Removal from State Important: I any injury o 4 Donation 5 Other (Specify) State Crem. 3/16/2012 Millsboro, DE 21. Signal r of uner rvice Licenses 22. Name and Address of Facility Burbage Funeral Home <u>108 William St., Berlin, MD</u> 21811 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on gaph line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Diabeter Mellitur Medical Due to (or as a consequence of): **Examiner** Frbrillation Atrial Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine nding physician and use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Hypertension Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No signed by the atte Month 4 Pregnant 9 Unknown Dav Pregnant at time of death Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 🔀 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed' certificate 1 ☐ Yes 2 ☐ No Yes 2 🔀 No Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 🗷 No Hospital Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \)Other (Specify, မ 1 Yes 2nd Home eral Director: After this filled in by the funeral dir 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred X Natural 5 Pending Accident
Suicide 1 🗌 Yes 2 🗆 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Funeral 29a. Certifier 😿 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 0101245203

BA5

Registrar MAR 1 6 2012

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

CHANA, MD; 10701 ROSEMARY DR., MANASSAS, 20109

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Servela Desrivieres 2072 0655 March Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months 056-50-4149 **Director** 1 □ M 2 🕱 F 74 02/02/1938 Haiti Usual Residence of Decedent 28a-f show 10a. State with the Maryland the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Prince George's Bowie 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 15001 Puffin Court 20721 U.S.A. death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 0 1 Never Married 2 Married ğ Yes 2 No 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify 'natural", Completed 3 X Widowed 4 Divorced Specify Black 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Counselor Ministry Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname, and Mental F မ Legene Germain Germaine Guerrier permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic any injury or other traumatic once. traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Naomie Polistin - Daughter 15001 Puffin Court, Bowie, Maryland 20721 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Gospel of the Kingdom
Campground Memorial Cem. 1 💹 Burial 2 🗌 Cremation 3 💢 Removal from State 03/25/2012 Shepherdsville, Kentucky 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home. Inc. Katrin 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph sician/ -Schomic disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter onderlying Cause (Disease or injury that initiated events Due to (or as a consequence of): e burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 use as the attending IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ___ for in the past 12 month Pregnant at time of death be detached the g Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy perform death? after death.

Director: After this certificate 1 Yes 2 No Yes filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 10 2 No Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State within 24 hours a

To the Funeral Completely filled Medical

Registrar

State

29a. Certifier (Check

29b. Signature and title of certifie

Keith Goulet.

MAR 22

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D.O.,

600 Ridgely Avenue.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

HUUDU182

#121, Annapolis, Maryland 21401

29d. Date signed (Month, Day, Year)

-16-12

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MARCH 8. 2012 BORIS DRABOVSKIY 12:40 P.M A. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY CASEY HOUSE ROCKVILLE Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Hours 216-45-0434 Director 1 X M 2 🗆 F Feb 20, 1938 74 Ukraine Usual Residence of Deced "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🗶 No Maryland Montgomery Rockville 10f. Zip Code 10g. Citizen of What Country? Funeral within 72 hours after death with #409 12630 Viers Mill Road. 20853 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🕱 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced white Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry n 27 is marked other than "n traumatic event" (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 3 Plant Supervisor Textile Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ Naroditskaya Aron Drabovskiy Enta 1 and 2 should the Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14303 Crazy Quilt Court, Boyds, MD 20841 Vadim Drabovsky. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1
Department of Important: If it any Injury or o of X Burial 2 ☐ Cremation 3 ☐ Removal from State Gdn of Remembrance Onation 5 Other (Specify) 3/11/2012 Clarksburg, Maryland e of Funeral/Service Licenses 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. nat 1100704 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Fi Onset and Death Physician/ CONGESTIVE HEART FAILURE Medical resulting in death) Examiner CARDIOMYOPATHY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of, the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) burial physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ jo in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 No detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe HODGKINS DISEASE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed Were autopsy findings available prior to completion of cause of has autopsy performed? Yes 2 No death? certificate 1 Yes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 **X** No 4 Nursing Home 5 Residence 6 X Other (Specify) မ Hospice 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No within 24 hours after death

To the Funeral Director: A

completely filled in by the f Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

State Registrar only one)

29b. Signature and title of certifier

Bindu Joseph,

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.,

2

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

6001 Muncaster Mill Road, Rockville, MD

D0060634

29d. Date signed (Month, Day, Year)

March 9, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deat Physician/ 2012^{Year} Nicholas Richard Dombo March 12, 9:1/2РМ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Holy Cross Hospital Silver Spring 5. Social Security Number 6 Sex 8. Date of Birth (Month, Day, Year) If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** None **Director** 1 🖁 M 2 🗆 F Yrs 0 0 17 Feb. 24, 2012 Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits notified at Director 1 🖾 Yes 2 🗌 No DC Washington 10e. Street and Number 10f. Zip Code items 23a or ner must be n 10g, Citizen of What Country? Funeral 20008 USA 3003 Van Ness Street, NW, Apt. W1005 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Armed Forces? Black, White, etc. White 1 Never Married 2 Married þ 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) N/A 0 None Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lada Yevgenyevna Devyatkina Michael Patrick Dombo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Der artment of Health ar Important: If item 27 is any injury or other trau once. 3003 Van Ness Street, NW, Apt. W1005, Washington, DC Michael Patrick Dombo/Father 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) March 15 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Gate of Heaven Cemetery Silver Spring, MD 4 Donation 5 Other (Specify) 2012 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1.10 ter the disease, or complications that caused the de the lo not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line. Immediate Cause (Final 17 days Physician/ Respiratory Failure disease or condition resulting in death) Medical Due to (or as a consequence of) 7 days Pulmonary Hypertension Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events 16 days Grade IV Intraventricular Hemorrhage Due to (or as a consequence of): resulting in death) Last Physician/Medical 17 days Extreme Prematurity at 23 weeks gestation IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Pregnant at time of death Month 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XXUnknown 24a. Was an Were autopsy findings available prior to completion of cause of autonsy death? 1 Yes 2 No Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 🛭 No 1 Yes မ 1 Marient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred

Examiner B requires that the death certificate be executed and physician s the buria Division of Vital Records, P.O. Box 68760 ding p nse Į, ed by the a signed by d Jas cate ha To the Hospital or Attending Physician: this funeral s after death.
I Director: After the of in by the funera within 24 hours after
To the Funeral Directory

28a-f show

ō

or

"natural",

and Mental Hygiene. is marked other than

nours after

Baltimore, Maryland 21215-0036

1 🔀 Natural

29a. Certifier (Check

5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 4 Homicide determined

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Grading Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28a. Date of injury (Month, Day, Year)

work?
1 Yes 2 No Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated DHGTI

29d, Date signed (Month, Day, Year) 3/12/2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1500 Forest Glen Road, Silver Spring, MD 20910 Sharon C. Kiernan, MD

31. Date filed (Month, Day, Year)

29b. Signature and title of certifie

Bharo

MAR 15 2012

ueruan, mi

State

Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar		(Certificate of	Death	,	Reg. No.	2 10071
	Physic	ion	1. Decedent's Name (First, Midd	dle, Last)				2. Date of Dea	ath Day Ye	3. Time of Beath
	/Medi			JANICE I.	DOLINA			MARCH	13, 201	
*	Exami	ner	4a. Facility Name (If not instituti				or Location of Dea	ath	4c. County of D	
	Free cont	-	HEARTLAND 1 5. Social Security Number	NURSING HOME 6. Sex 7. Age	e (In yrs. last birth		TTSVILLE	s. 8. Date of Birt		E GEORGE S Birthplace (State or Foreign
	Funeral Director		577-56-5745 Usual Residence of Decedent	1 □ M 2 X F		Months Days			y, Year)	Country) PA.
	yland yland		10a. State 10b. Count	у	10c. City, Town	or Location				10d. Inside City Limits
	a-fsh	Director	MD. PRINC	CE GEORGE'S		HYATTSVII	LLE			1 X Yes 2 □ No
	or 28	Dire	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?
	ath w			LWORTH AVE.			0781		U.S.A	
	item item	Funeral	11. Marital Status 1 □ Never Married 2 ☒ Ma	12. Was Decedent B Armed Forces? 1 ☐ Yes 2 ☐		 Was Decedent of I If Yes, specify Cub 	Hispanic Origin? (an, Mexican, Pue	Specify Yes or No rto Rican, etc.)	- 14. Race - A Black, W	American Indian, /hite, etc.
21215-0036	be filed within 72 hours after death with the Maryland that Hygiene. dother than "natural", or items 23a or 28a-f show event, the Medical Exemples must be redified at	b	3 ☐ Widowed 4 ☐ Divorce	d Year or Dates:		1 ☐ Yes 2 📉 No				WHITE
15	in 72 in "nat	Completed	(Specify only high	ent's Education est grade completed)	(Decedent's Usual Occu Give kind of work done life. DO NOT use retire	during most of wo	orking	16b. Kind of Busine	ess/Industry
212	2 should be filed withir n and Mental Hygiene. is marked other than raumatic event, the M	mo.	Elementary/Secondary (0-12)	College (1-4or 5	+)	DANCER	-/		DANCI	NG
	e filec al Hyg othe vent,	Be C	17. Father's Name (First, Middle	e, Last)			18. Mother's Na	ame (First, Middle,	Maiden Surname)	
Maryland	Ment barked	은	RONALI	SCHREF	FLER			GRACE	LOOKE	NBILL
lar	2 sho and ism raum		19a. Informant's Name/Relation	ship (Type. Print)	19b.	Mailing Address (Street	and Number or F	Rural Route Numbe	er, City or Town, Stat	te, Zip Code)
	s 1 and 2 should of Health and Mer ttem 27 is marke other traumatic		JIMMY DOI 20a. Method of Disposition	INA/HUSBAND		08 KENILWOF		, HYATTSV	VILLE, MD.	
Baltimore,	Page nent o int: If iry or		1 ☐ Burial 2 【X Cremation 4 ☐ Donation 5 ☐ Other ((Disposition (Name of crematory or other plants of CREMATOR	RY 3-1	4-2012	RIVERDAL	•
Ball	permit. Departn Imports any Inju		21. Signature of Funeral Service	e Licensee Aumilieux	M00091	22. Name and Addre CHAMBERS I 5801 CLEVE	TUNERAL I	HOME & CR	REMATORIUM	P.A. 20737
			23a. Part 1. Enter the disease, of shock, or heart failure. Lis	or complications that caused st only one cause on each lin	the death. Do no					Approximate Interval Between
-	Physician		Immediate Cause (Final disease or condition	Caroba	Nascu	or Acci	dent			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	a consequence of		11			
		ja	Sequentially list conditions,	b. Due to (or as a	a consequence of	reguard	patty			
	nted a	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	1 Tamins	1 Mot	astatic Z	octal (arcino.	mo	
oʻ	ficate be executed physician and s the buriatives		that initiated events resulting in death) Last	Due to (or as a	consequence of	:	4			
68760,	ate by hysici the bu	Medical		d. Pantor	real (arcinom	atosis			
9	ertific ling p e as t	Mec	IF FEMALE:							
.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and age 2 should be detached for use as the burist should	Physician/	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death	3 ☐ Ectopic pregnand 5 ☐ Other (specify)	ру 		23d. Date of Month	delivery Day Year
Э.	s that ned b deta		Part II. Other significant condit	ions contributing to death bu	it not resulting in t	he underlying cause giv	ven in Part I.	23e. Did to	obacco use contribute	e to the cause of death?
Vital Records,	w requires been sign should be	ed by	eltorino C	arcuerna	•			101	res 2 2 0 No 3 □] Probabily 4 ☐ Unknown
မင္ပ	law re as be 2 sho	Completed	Sarun	v Disirde	2			24a. Was		autopsy findings available
		E O	Hypoo	Fancier				perfo	rmed? death	
Vita	siclan; certific rector,	Be	25. Was case referred to medica examiner?					eath (Check only o	ne)	
of	Physician: r this certific ral director, p	၉	1 Yes 2 Mo		nt 2 ER/Outp		4 Er Nursing		dence 6 Other (5	Specify)
	ding h. After fune	ion	27. Manner of Death 1 Natural 5 Pendi	ng 28a. Date of Injur (Month, Day tigation	y 28b. Tii , <i>Year)</i> 28b. Tii	iry Wor	ryat k? Yes 2□No	28d. Describe h	now injury occurred	
Division	or Attending after death. Director: After I in by the funer	fica	3 ☐ Suicide 6 ☐ Could	I not be 28e. Place of Inju	ry - At home, farn	, street, factory, office	1165 2 1140	28f. Location (5	Street and Number or	r Rural Route Number.
=	at or A s after al Dire	Certification:	4 ☐ Homicide determ	building, etc	." (Specify)	•		City or Tov		,
	To the Hospital or Atten within 24 hours after deati To the Funeral Director: completely filled in by the	ledical (29a. Certifier 1 Certifyi (Check only one) 2 Medica	ing Physician: To the best of Examiner: On the basis of and manner sta	examination and	death occurred at the ti or investigation, in my	ime, date and place opinion, death occ	ce, and due to the curred at the time,	cause(s) and manne date and place, and	er as stated. due to the cause(s)
	To the within 2 To the complet	Ž	29b. Signature and title of certific	er		29c. Licens	se number		29d. Date signed (M	onth, Day, Year)
	•		##	70		4	47867		3/13/20	12
			30 Name and address of person	who completed cause of de	eath (Item 23a) (T Pando/p	(pe, Print) 4 Rd # Z	16. Roc	Kville, 1	40 2085	72
	Sta Registr		31. Date filed (Month, Day, Year MAR 15 2	2. Registra	r's Signature	29c. Licens 4 /pe, Print) // Pd # 2				

			Plea	se Type o								-		_	ble.	
		For State AMEN	\D#12nerT	State NF,3/19/1				partmer e <i>rtificat</i>			and N	lental Hy	0	0.0	1 0	10075
		Registrar Decedent's Name			_,	<i>j</i>		Crancat	COIL	Catii		2. Date of D	Reg. N eath	°. 2 U	12	3. Time of Death
Physicia Medic		Helen		elgall								Month 03	ة ا		Year 312	3:20 PM
Examin	er	4a. Facility Name (if Universit	4 80 M	give street and n	umber) Ledic	cal C	enter	Ba	Stim	Location of			4	c. County o	f Death	
Funeral Director		5. Social Security No. 212-78-9		6. Sex 1 ☐ M 2 💢 I	-	e (In yrs. Ia		Months	Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D			9. Birthp Count	lace (State or Foreign ry)
		Usual Residence	of Decedent	1 L W 2 X		70	Yrs					FEB. 2	20,1	942	VIE	TNAM
ryland I-f sho ied at	ctor	10a. State	10b. County			10c. City	y, Town or								10	Od. Inside City Limits
he Ma or 28a o notif	Director	MD. 10e. Street and Nun		E GEORGE	i'S			LAN					10a. C	itizen of Wh	nat Coun	1 X Yes 2 □ No
s 23a uust bo	Funeral	6718	LAMONT	r Dr.						2070	6			U.S		
r item iner m		11. Marital Status		12. Was De Armed	Forces?		S. 1	3. Was Dece	dent of Hi cify Cuba	spanic Ori n, Mexicar	gin? (Spe	cify Yes or No Rican, etc.)	-	14. Race Black	- America White, e	
s after ral", o Exam	ed by	1 ☐ Never Marr 3 ☐ Widowed		If Yes, Year or		-UNK	-	1 🗌 Yes	2 XNo	Specify:				Specify:		IAN
2 hour	Completed	(Spe	15. Decedent	t's Education at grade complete	<i>∋d)</i>		(Gi	cedent's Usu	ork done o	ation luring mos	t of worki	ing	16b.	Kind of Bus		
ithin 7 jene. r than the M	Com	Elementary/Seco	ondary (0-12)	College	(1-4 or 5	5+)		. DO NOT us IECHAN		OPER	ΔΤΩΡ		Δ	EROSPA	ACE	CORP.
filed wall Hygal dothe	Be (17. Father's Name (First, Middle, La	ast)			1		NK.			e (First, Middle			<u>aon</u>	CORT .
should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	2										THI		XIM_	TRU		
1 and 2 should be if Health and Men item 27 is marke other traumatic		19a. Informant's Na	ame/Relationshi DEL GAI				19b. Ma					HAM,MI			ite, Zip C	ode)
of Health of Health of Item 27 i		20a. Method of Disp	position				lace of Dis	sposition (Na	me of			Date		Location - C	City or To	wn, State
Page tment tant: h jury or			5 Other (Sp	3 Removal from the control of the co	om State	1		S CRE			3-15	-2012	R	IVERD	ALE,	MD.
permit. Page 1 a Department of H Important: If ite any injury or ot		21. Signature of Fu		einsee MMleux	10	- MOO	091	CHAMBI	ERS I	UNER	ÄL H	OME & (CREM	ATORII	UM, P	.A.
		23a. Part 1. Enter t		complications that		d the death								<u> </u>		Approximate Interval Between
hysician/ Medical		Immediate Cause (disease or condition resulting in death)		a. Her	nop	hago	auti	<u> 541</u>	nda	me						Onset and Death
Examiner		resulting in death)	- 1			a consequ										
- #4	iner	Sequentially list co if any, leading to in cause. Enter Under	nmediate	D		a consequ										
s executed vian and unial transit	Examiner	Cause (Disease or that initiated events resulting in death) I	injury ts	C	to for as	A consequ	ully	faile	uve						\rightarrow	
sician burial		resulting in death) i	Last			toper										
tificate ng phy s as the	Physician/Medical	IF FEMALE:			1	14-0	11-5									
ath cer attendi for use	cian/	23b. Was decedent in the past 12 r	months?		ve Birth		death	B		у				23d. Date Mont		ry Day Year
the de	hysi	1 Yes 2 1 9 Unknown			nknown	it time or c	icatii .	Other (s)								
requires that the death certificate be been signed by the attending physic should be detached for use as the by		Part II. Other signif						1						_		e cause of death?
require been s should	eted	CMV posi		ood (UH	ures	, court	⊃ (v Y\Y)	iurje v	UCY	Muc						ably 4 Unknown
he law te has age 2 :	Completed by	disorde										_ per	opsy formed?	pr de	or to con ath?	sy findings available npletion of cause of
Physician: The la this certificate ha al director, page	BeC	25. Was case referre	ed to medical						26. Pla	ace of Dea	th (Check	1 🗌 Yes (only one)	2 1	No 1	Yes	2 <u> </u>
Physic this ce al dire	မ		No h		_			tient 3 D	_	4 □ N		me 5 Res				
tth. : After e funer	cate	1 Matural 2 Accident	5 Pending Investiga	(M	te of inju onth, Dag		28b. Time injur		28c. Injury work 1 🗌		. 1	28d. Describe	how inju	iry occurred	I	
or Atter trer dea irector n by th	Certificate:	3 Suicide 4 Homicide	6 Could n determin	ot be 28e. Pla		ury - At ho c. (Specify		street, factor	y, office			28f. Location			or Rural	Route Number,
spital cours al cours		29a. Certifier 1	Certifying	Physician: To the	e best of	my knowl	edge, dea	th occurred a	at the time	date and	I place a	_		·	r as state	rd.
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has I completely filled in by the funeral director, page 2 s.	Medical	Check 2	∠	caminer: On the l	oasis of e	xamination	n and/or inv	estigation, in	my opinic	n, death or	ccurred at	the time, date	and plac	e, and due t	o the cau	se(s) and manner stated
		29b. Signature and	title of certifier		MT	>			P 2	number 735	-			ate signed (
6		30. Name and addre				leath (Item	23a) (Type	e, Print)		_		i		•	<u> </u>	
		Negar 31. Date filed (Month						e St	- g	Balt	Mor	e Mi	<u>S</u> 6	1120	1	
Star Registra			R 15 20	12 Sen	. Hegistra	ar's Signat	ure A G	Jes,								

		Plea - For	a se Type or I State of			artment of F		•		jible.	
	_	State Registrar 1. Decedent's Name (First, Middle	(act)		Cei	tificate of L	Death	2. Date of Dea	Reg. No.	0 2-	J 007(
Physicia Medic		GERALDINE RUBY		YE				MARC :I	Day 14,	2012	3. Time of Death 1
Examin		4a. Facility Name (if not institution RESIDENCE 5925	_		AD	4b. City, Town, or INDIAN		th	1	y of Death	
Funeral Director		5. Social Security Number 045–22–8472	6. Sex 7	. Age (In yrs. Id		If Under 1 Year Months Days	If Under 24 Hrs Hours Min	. (Month, Day	h , Year)	9. Birthplac Country)	
3	Ļ	Usual Residence of Decedent 10a. State 10b. County	T LI WI Z LEFF		Yrs. y, Town or Lo	cation		MARC 1	3,1928	1	CTICUT
Marylan 28a-f sh	irecto	MARYLAND CHARI	LES		DIAN HI					100	1 Yes 2 X No
filed within 72 hours after death with the Maryland al Hygiene. d other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at	Funeral Director	10e. Street and Number 5925 PORT TOBAC	CCO ROAD			10f. Zip Code 20640			10g. Citizen of	What Country STATE	
death v		11. Marital Status 1 Never Married 2 Mar	12. Was Deced Armed Ford	es?		Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (S an, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Ra	ce - American	Indian,
urs after ural", o al Exam	ted by	3 Widowed 4 X Divorced	If Yes, Give Year or Date			I ☐ Yes 2 X No	Specify:		Specify	BLACK	
n 72 hor s. an "nat Medica	Completed		nt's Education est grade completed) College (1-4	Lor 5+)	(Give	dent's Usual Occup kind of work done o O NOT use retired)	ation during most of wo	orking	16b. Kind of E	Business/Indus	stry
ed withi Hygiene other th	a l	12TH GRADE 17. Father's Name (First, Middle, L			EXPL	OSIVE WO		me (First, Middle, I		L GOVE	RNMENT
should be filed within 72 h and Mental Hygiene. 7 is marked other than "raumatic event, the Med	٥	ROYALE WILSON						ELLE JAN]			
1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hyglene. If Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationsh GLORIA DAYE / D				ng Address (Street a					AND 20640
permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau		20a. Method of Disposition 1 🗐 Burial 2 🚺 Cremation	3 Removal from S	State C	lace of Dispo emetery, crer	sition (Name of natory or other plac	ce)	Date	20c. Location	- City or Town	n, State
permit. Page Department o Important: If any injury or once.		4 Donation 5 Other (S	,	BRIN	22	CHOLS CREMA 2. Name and Addres	ss of Facility		CHARLO		_
or and De			NTON JOHNS			HORNTON 1				,	YLAND 2064C
Physician/		shock, or heart failure. List of Immediate Cause (Final disease or condition	only one cause on each	hemic	hen	rt ars:	ţ	o or rospiratory are	550,	l In	nterval Between Inset and Death
Medical Examiner		resulting in death)	Due to (o	r as a consequ	uence of):	11, hu	and				U 26 T
gi, d	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (o	r as a consequ	uence of):	and	4,00				J=-V)
be executed sician and burial-transit		that initiated events resulting in death) Last		r as a consequ						- 4	y ar !
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicis completely filled in by the funeral director, page 2 should be detached for use as the but	edical		d. 17	ratin	wen.	<u> </u>					Jers
th certifi tending or use a	ian/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		irth 2 ∐ Feta	ıl death 3 ∟	Ectopic pregnanc	ру			ate of delivery	. Vene
the dear	by Physician/Medic	1 ☐ Yes 2 X No 9 ☐ Unknown	4 ☐ Pregna 9 ☐ Unkno	ant at time of o	death 5 L	Other (specify)			M	onth Da	ay Year
res that signed t	d by F	Part II. Other significant condition		ath but not res	_	ınderlying cause giv	ven in Part I.	1			cause of death?
as been 2 shoul	Completed				7			24a. Was a autop:	ın 24b.	Were autopsy	r findings available bletion of cause of
n: The la ficate ha		25. Was case referred to medical					(2.11.10)	perfor 1 \sum Yes	med? 2 X No	death?	
hysicia his certi al direct	To B	examiner? 1 Yes 2 No		patient 2 🗆		nt 3 DOA Othe	4 L Nursing	Home 5 Resid	ence 6 🗆 Oth	ner (Specify)	
nding Path. r: After t	Certificate:	27. Manner of Death 1 Natural 5 □ Pendin 2 □ Accident Investig	y ·	f injury , Day, Year)	28b. Time of injury	work	yat :? Yes 2 □ No	28d. Describe ho	ow injury occur	red	
or Atte after de: Director in by th	Certif	3 Suicide 6 Could 4 Homicide determ	inad 28e. Place o	f Injury - At ho g, etc. (Specify	me, farm, str	eet, factory, office		28f. Location (Si City or Town		er or Rural Ro	oute Number,
lospital t hours uneral l ely filled	Medical		Physician: To the best								e(s) and manner stated
To the F Within 24 To the F Somplet			Nurse Practitioner:				he time, date and	place, and due to th		manner as stat	ted.
×		1 2		1			3426		MARC 1	5, 201	2
00		30. Name and address of person B. LARRY JENKIN	IS, M.D.	of death (Item	23a) (Type, F	11/	A GRANGE	AVENUE YLAND 20	0646		
Stat Registra	e Ir	31. Date filed (Month Day Year)		gistrar's Signal	ture &						
			1		7						

	Plea		or Print in					-		Legible	
For State		State	of Marylar					Mental Hy	giene		
Registrar 1. Decedent's Nam	ne (First, Middle,	, Last)		Ce	rtificate	OT DE	eatn	2. Date of De	Reg. No.	2012	3. Time of Death
Sally El	lliott							Month 3	5 ^{Day}	2012	
4a. Facility Name (iii	f not institution,	give street and r	number)		4b. City, To	own, or L	ocation of Death)		County of Deat	
20001 Ge 5. Social Security N		Avenue 6. Sex	7. Age (In yrs. I	ast hirthday)	Brook		Lle If Under 24 Hrs.	8. Date of Bir		ntgomer	
089-14-5		1 ☐ M 2 X		Yrs.			Hours Min.	(Month, Da		9. Bir Co	thplace (State or Foreign untry)
Usual Residence								11-13-	-1924		New York
				y, Town or Lo okevil							10d. Inside City Limits Yes 2 No
MD 10e. Street and Nur	Montgo mber	omery	БГО	okevii	10f. Zip C	Code		T	10a. Citiz	en of What Co	
20001 Ge	eorgia .	Avenue			208	833				d Stat	•
11. Marital Status		Armed	ecedent Ever in U. Forces?		Was Deceder	nt of Hisp y Cuban,	anic Origin? (Sp Mexican, Puerto	ecify Yes or No- Rican, etc.)	- 14	4. Race - Ame Black, White	
1 ☐ Never Mari 3 🗶 Widowed		1 ☐ Yes, Year or			1 ☐ Yes 2∑	No No	Specify:		Sį	pecify:	White
(Spe		it's Education		16a. Dece	dent's Usual	Occupati	on ing most of work	kina	16b. Kin	d of Business	/Industry
Elementary/Seco		<u> </u>	e (1-4 or 5+)	life. D	O NOT use re	etired)	g most or wor	ig	0	Home	
12 17, Father's Name ((First, Middle, La	ast)		Гношен	iakel	1	8. Mother's Nan	ne (First. Middle			
Irving (Greenwa	1d						ta Weir			
19a. Informant's Na	ame/Relationsh	ip (Type, Print)					d Number or Rui				
Todd E13		Son	OOL 1				Avenue,				and 20833
	☐ Cremation	3 Removal fr	om State	emetery, crei	matory or oth	er place)		Date		ation - City or	
21. Signature of Fu				ean Me	em. Gan	Address	of FacilityEdwa	-2012 ard Sage	el Fu	ey, Mar neral I	yland Direction Inc
1/5	2	fe	#M0147	7 10	91 Roc	ckvi	lle Pike	e, Rocky	ille,	Mary1	and 20852
	irt failure. List oi	complications th nly one cause on	at caused the deat each line.	h. Do not ent	er the mode of	of dying,	such as cardiac	or respiratory ar	rrest,		Approximate Interval Between
Immediate Cause (disease or condition resulting in death)		a	nal Failu								Onset and Death 6 weeks
			to (or as a consequ pertensio								
Sequentially list co if any, leading to in cause. Enter Unde	nmediate	D	to (or as a consequ								
Cause (Disease or that initiated event	injury s	C. —	to (ov oo o ooooo								
resulting in death)	Last	d.	to (or as a consequ	ience oi):							
		d			-						
IF FEMALE: 23b. Was decedent in the past 12			outcome of pregna		Ectopic pre	eanancv			23	3d. Date of de	livery
1 Yes 2 Unknown	X No	4 🔲 Pi	regnant at time of on		Other (spec					Month	Day Year
Part II. Other signif		ns contributing to	o death but not res	ulting in the u	underlying car	use giver	in Part I.	23e. Did t	obacco use	e contribute to	the cause of death?
Failure	e to th	rive			- 1 -			1 🗆	Yes 2 🗘	KNo 3□P	robably 4 🗆 Unknown
.								24a. Was		24b. Were au	topsy findings available completion of cause of
								perfo	ormed? 2 K No	death?	2 🗆 No
25. Was case referrence examiner?		Hospital:				Other	e of Death (Chec				
27. Manner of Deat	h _	28a. Da	Inpatient 2 Late of injury fonth, Day, Year)	28b. Time of		c. Injury a		ome 5 🔀 Resi			ify)
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide	5 ☐ Pending Investig 6 ☐ Could n	ation	ontri, Day, Year)	injury	М	work?	s 2 🗆 No				
4 Homicide	determi	pod 28e. Pla	ice of Injury - At ho ilding, etc. <i>(Specif</i>)	me, farm, str	eet, factory, c	Office		28f. Location (S City or Tov		Number or Ru	ral Route Number,
29a. Certifier 1	X Certifying	Physician: To th	e best of my know	edge, death	occurred at th	he time, c	date and place, a	and due to the c	ause(s) and	I manner as st	ated.
(Check 2	≧ L. Medical Ex	xaminer: On the l	pasis of examination ner: To the best of r	and/or inves	tigation, in my	opinion.	death occurred a	at the time, date a	and place, a	ind due to the	cause(s) and manner stated.
29b. Signature and	title of certifier				29c. L	icense n				signed (Month	h, Day, Year)
30. Name and addre	ess of person ::	the completed		33a) (Time 1	Print)	D5:	3528		3-6-2	2012	
			B121 Geor	, , , , ,	,	Ste	#103,	Olney, N	Mary1a	and 208	332
31. Date filed (Mont	h, Day, Year)	32	. Registrar's Signa								
MAK	1 4 201	L Chris	an B.	1961	<i>A</i>						

DHMH 17 Rev 06-2011

15

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 4:50 P M Donald George Ehrhardt March 16 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 7471 Rosewood Manor Lane Montgomery Gaithersburg 9. Birthplace (State or Foreign . Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Hours Min (Month, Day, Year) **Director** 578-50-1640 1 XM 2 □ F 74 March 25 1937 Maryland Usual Residence of Deced show 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f 1 Yes 2 X No MD Montgomery Gaithersburg 10e. Street and Number ò 10g. Citizen of What Country? r must be r Funeral 7471 Rosewood Manor Lane 20882 USA items filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status ed other than "natural", or ite event, the Medical Examiner Armed Forces?

1 X Yes 2 No Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 1959 1 ☐ Yes 2 X No Specify: White Completed 3 Widowed 4 Divorced Year or Dates 1962 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than International College (1-4 or 5+) Elementary/Secondary (0-12) d Mental Hygiene. marked other tha Administrative Support Business Machines Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Inga Colby ortant: If item 27 is marke injury or other traumatic George Frederick Ehrhardt and N is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7471 Rosewood Manor Lane, Gaithersburg, MD 20882 Ursula Maria Ehrhardt/Spouse Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot once. 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crem. 03/17/2012 Alexandria, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility DeVol Funeral Home Willian MO1202 10 E. Deer Park Drive, Gaithersburg, MD 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Years Physician/ disease or condition resulting in death) Squamous Cell Carcinoma Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of). if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician use as the buris Physician/Medical death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Pregnant 5 Other (specify) Month Day Year Pregnant at time of death the To the Hospital or Attending Physician: The law requires that the within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? b Division of Vital Records, 1 Yes 2 No 3 Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 A No 1 Tes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 K Residence 6 Other (Specify) 1 🗌 Yes 2 🗶 No 2 1 Inpatient 2 ER/Outpatient 3 DOA Date of injury (Month, Day, Year) Manner of Death 28a. 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 X Natural 5 Pending work? 1 🗌 Yes 2 🗌 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🗶 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

mpletely filled in by the funeral

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) March 17, 2012 D47682

30. Name and address of person who completed cause of death (tem 23a) (Type, Print)

M.D., 2901 Olney-Sandy Spring Road, Olney, MD 20832 Bennett T. Morrison,

State Registrar (Check

. 2012 Year Physician/ March 14, Ellis George Cyrus Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Suburban Hospital Bethesda Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days Hours (Month, Day, Year) 578-42-8269 1 🖾 🛣 1 2 🗆 F Director 81 Aug. 22, 1930 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City. Town or Location with the Maryland notified at Director MD Rockville Montgomery 10e Street and Number ò 10f. Zip Code 10g. Citizen of What Country? items 23a or ner must be n Funeral 2013 Gainsboro Road 20851 USA within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, the Medical Examiner ed Forces?
Yes 2 \(\sigma\) No Armed Fo 10 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates Korea 1 Yes 2 No Specify: "natural", 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12 Landscaping Landscaper and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ George Cyrus Ellis, Sr. Sarah Gibson Page 1 and 2 should ment of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 is any injury or other trau once, Josephine M. Ellis/Wife 2013 Gainsboro Road, Rockville, MD 20851 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 K Burial 2 Cremation 3 Removal from State March 2012 20 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery Silver Spring,MD Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, Part Unter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final CORONARY ARTONY Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Due to or as a consequence of and B Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 þ 2 No 3 ☐ Probably 4 ☐ Unknown Records, 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 , page 2 Hospital or Attending Physician: The Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 Impatient 2 ER/Outpatient 3 DOA W 28a. Date of injury (Month, Day, Year) Division of Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 350R6E 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Gentlying Nutrie Practition on To the cent of my incoming of a time time, date and place, and due to the cause(s) and manner stated. (Check To the

For State Registrar

Decedent's Name (First, Middle, Last)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2. Date of Death

7:50

Birthplace (State or Foreign Country)

Washington, DC

10d. Inside City Limits

1 X Yes 2 No

MD 20901

Year

Onset and Death

Montgomery

Black White etc.

Month

29d. Date signed (Month, Day, Year)

3115112

Day

1 🗆 Yes 2 🛂 No

рм

DHMH 17 Rev 06-2011

Registrar

10+1

29b. Signature and title of certifier

31. Date filed (Month, Day, Year,

MAR 19 201

a, MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Truong Bao, MD 8600 Old Georgetown Road, Bethesda, MD 20814

29c. License number

00057124

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Clark Flemister, Jr. Harvey 2012 рм 7:35 March 18 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Silver Spring 512 Highgate Terrace Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours (Month, Day, Year) 215-20-3858 1 🛂 M 2 🗆 F Director Yrs 85 June 15, 1926 FL show 10a. State 10c. City, Town or Location the Maryland at 10d. Inside City Limits Director notified 28a-f MD 1 Yes 2 No Montgomery Silver Spring 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? ms 23a or must be r Funeral 20904 USA 512 Highgate Terrace iral", or items 2 Examiner mus permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner m 11 Marital Status Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. by 1 Never Married 2 Married 2 No Specify: White 1 Yes 2 XNo Specify: If Yes, Give Year or Dates. 1945-46 Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Federal Government FBI Special Agent Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Lillian Hagerman Harvey Clark Flemister 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 512 Highgate Terrace, Silver Spring, MD 20904 Marjorie Flemister/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State March 23, MX Burial 2 Cremation 3 Removal from State St. Mark's Episcopal Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) 2012 22. Name an Address of Facility Francis J. Collins Funeral Home 500 University Blvd. W., Silver Sign Mr. of Funeral Service of ensee Inc. Spring, MD 20901 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Arrhythmia Acute disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Congestive Heart Failure Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) • Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
• Funeral Director, After this certificate has been signed by the attending physician and and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 5 Other (specify) Month Year Pregnant at time of death 1 Yes 2 9 Unknown ed by the a detached f 9 Unknown is certificate has been signed by director, page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 X N Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: ည 1 Tes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director; After this completely filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural iniury 5 Pending Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Medical 29a. Certifier 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 29c. License number 29d. Date signed (Month. Dav. Year) 2

Registrar
DHMH 17 Rev 06-2011

State

10+1

21215-0036

Baltimore, Maryland

Division of Vital Records, P.O. Box 68760

10400 Connecticut Avenue, #606, Kensington, MD 20895

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bradley Hunter, DO

31. Date filed (Month, Day, Year)

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	Otate of Maryland		tificate of L			Reg. No. 201	2 10081
	Physicia	an/	1. Decedent's Name (First, Middle, Last)					2. Date of Dea	ath	3. Time of Death
2	Medic	cal	MARY EI 4a. Facility Name (if not institution, give si	LIZABETH	FLAH		Landin of Dark	M _B nth	Day 2017	
-	Examir	ier	National Lutherar			Rockvil	Location of Death .1e	1	4c. County of De Montgo	
	Funeral Director		5. Social Security Number 6. Sex 217-44-3161 Usual Residence of Decedent	7. Age (In yrs. Ia 91	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Pay, 03 14	9. E Was 1921	Sirthplace (State or Foreign Notification, D.C.
	Maryland 28a-f show otified at	Director	10a. State 10b. County Maryland Montgome		Town or Lo					10d. Inside City Limits 1 Yes 2 □ No
	is 23a or 2	Funeral Di	10e. Street and Number 9701 Veirs Drive			10f. Zip Code 20850) - 3462		10g. Citizen of What C United Sta	*
9000	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	2. Was Decedent Ever in U.S Armed Forces 2 1 Yes 2 No If Yes, Give Year or Dates.	- 1	Was Decedent of Hi f Yes, specify Cuba I ☐ Yes 2 🛣 No		pecify Yes or No- o Rican, etc.)	14. Race - An Black, Wr Specify:	nerican Indian, ite, etc. White
Baltimore, Maryland 21215-0036	/ithin 72 hor lene. r than "nat the Medica	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Seconday (0-12)		(Give . life. D	dent's Usual Occup kind of work done o O NOT use retired) Administrat	luring most of wor	king	16b. Kind of Busines	
land 2	d be filed w Mental Hyg arked othe rtic event,	To Be	17. Father's Name (First, Middle, Last) Charles W. Brooks					ne (First, Middle, M en R. Ruff		
, Mary	nd 2 should salth and N n 27 is me er trauma		19a. Informant's Name/Relationship (Typ Virginia Achstetter	1 1		ng Address (Street a Palm Sprin			; City or Town, State, 2 1d。 20878	Zip Code)
imore	Page 1 ar ment of He tant: If iter iury or oth		20a. Method of Disposition 1 🚻 Burial 2 🗆 Cremation 3 🕇 F 4 🗆 Donation 5 🗀 Other (Specify)	Removal from State	metery, cren ional M	sition (Name of natory or other plac emorial Par	k March	Date 18,2012	20c. Location - City Falls Chu	ırch,Va.
Balt	permit. Departi Import any inj once.		21. Signature of Funeral Service Licensee	hallo?	22	Name and Addres	ss of Facility Dani lle Pike,	zansky-Gol Rockville,	Md. 20852	al Chapels
~	Physician Medical Examiner		23a. Part 1. Ento the disease or complishock, of heart failure. List only one immediate Cause (Final disease or condition resulting in death)	cations that caused the death cause on each line. Due to (or as a consequence)	in .	Per the mode of dying		or respiratory arre	est,	Approximate Interval Between Onset and Death
		Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or linjury that initiated events	Due to (or as a conseque	ence of):					
8760	te be exect hysician an he burial-tr	Medical Ex	resulting in death) Last	Due to (or as a conseque	ence of):					
. Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and to the Funeral Director, the funeral director, page 2 should be detached for use as the burial-transit.	5	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 X No 9 Unknown	Bc. If yes, outcome of pregnan 1 Live Birth 2 Fetal 4 Pregnant at time of de	death 3	Ectopic pregnanc Other (specify)	у		23d. Date of a	lelivery Day Year
ls, P.O	uires that the signed by the signed by the detail	ğ	Part II. Other significant conditions con	tributing to death but not resu	lting in the u	nderlying cause giv	en in Part I.			to the cause of death? Probably 4 Unknown
Division of Vital Records, P.O.	rsician: The law req s certificate has bee lirector, page 2 shou	Completed						24a. Was a autops perfon	sy prior to med? death?	autopsy findings available occupletion of cause of
ta	cian: entific ector,	Be	25. Was case referred to medical examiner?	ospital:			ace of Death (Chec			
Ϋ́	ding Physician: h. After this certific funeral director,	<u>ا</u>	1 ☐ Yes 2 🕅 No	1 Inpatient 2 E	R/Outpatier 28b. Time of		4 LX Nursing H		ence 6 Other (Spe	ecify)
ion o	tending death. tor: After the funer	Certificate:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	(Month, Day, Year)	injury			28d. Describe ho	ow injury occurred	
Divis	To the Hospital or Attend within 24 hours after deatl To the Funeral Director: Completed filled in by the		4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)				City or Town		
	he Hosp in 24 ho he Fune ipleted f	Medical	(Check 2 L Medical Examine	ian: To the best of my knowle er: On the basis of examination Practioner: To the best of my	and/or invest	igation, in my opinio	n, death occurred a	at the time, date an	nd place, and due to the	e cause(s) and manner stated.
	Zon Tot		29b. Signature and the of certifier	nall is	w	29c. License			29d. Date signed (Mor	
			30. Name and address of person who cor		23a) (Type, F	Vaire L	Drive D	ade alla	Malay	6,201L 20850
Į.	Stat Registra		31. Date filed (Month, Day, Year) MAR 2.1 2012	3. Registrar's Signatu		Mad.		UCCUINT.	"INKILAN	, = 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

			For State Registrar	State of Ma	aryland / De	partment of l ertificate of l	Health and			012 10082
	Physicia Medi Examir	cal	Decedent's Name (First, Middle, Las MARCELLA 4a. Facility Name (if not institution, give	R FITZ	-PATRIC		r Location of Deat	2. Date of De Month	19.	3. Time of Death 9:45 a M
	Exami	iei	Medstar Montgomer		Center	01ney	r Location of Deat	11	Mont	ty of Death Egomery
	Funeral Director		5. Social Security Number 6. Sec. 193–18–1468 1 Usual Residence of Decedent	7. Age M 2 K F 87	(In yrs. last birthday Yrs.) If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		ıy, Year)	9. Birthplace (State or Foreign Country) PA
	Maryland :8a-f shov rtified at	Director	10a. State 10b. County MD Montgo:	merv	10c. City, Town or I	Location Spring		•		10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	s 23a or 2	Funeral Di	10e. Street and Number 15115 Interlache			10f. Zip Code 20906			10g. Citizen o	f What Country?
9003	is filed within 72 hours after death with the Maryland tal Hyglene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 🛣 Yes 2 🗌 I If Yes, Give Year or Dates.	ver in U.S. 13	B. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🛣 No		pecify Yes or No- to Rican, etc.)		ace - American Indian, ack, White, etc. fy,White
21215-0036	ed within 72 ho Hygiene. other than "nat ent, the Medica	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)		(Giv	edent's Usual Occup le kind of work done DO NOT use retired) acher	during most of wo	rking		Business/Industry ic Schools
Maryland 2	ould be filed w d Mental Hyg marked othe matic event,	To Be	17. Father's Name (First, Middle, Last) George W. Smit	h, Jr.	100	201101	l	me (First, Middle,	Maiden Surnar	ne)
	1 and 2 should be if Health and Men item 27 is marke other traumatic		19a. Informant's Name/Relationship (Ty Donald F. Fitzpa	, , ,	and 15					State, Zip Code) 20906 1ver Spring, MD
Baltimore,	t. Page rtment c rtant: If njury or		20a. Method of Disposition 1 X Burial 2 Cremation 3 4 Donation 5 Other (Specify	()	Gate of	position (Name of ematory or other place Heaven Ce	metery	Date larch 22 2012	Silver	- City or Town, State - Spring, MD
Ba	Depar Impo any ir		21. Signal e of Funeral Service Lice	Scerl		22. Name and Addre rancis J 00 Univers				Inc. pring, MD 20901
Ä	hysici an/ Medical		23a. Part 1. Enter the disease, or come shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ne cause on each line.	the death. Do not e					Approximate Interval Between Onset and Death
	Examiner	er	Sequentially list conditions,	b. ———	RHAB DO	Myolys	75			24
	e be executed ysician and he burial transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	consequence of):	ARTENI	Al 150	Hemir	+	36
200	cate be ex physiciar s the buria	edical	C	d	ATRIAL	FIBRILL	ATION			
. Box 6876	ss that the death certificate b igned by the attending physi be detached for use as the b	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of Live Birth 2 4 Pregnant at 9 Unknown	Fetal death 3	☐ Ectopic pregnand ☐ Other (specify) _	су			Date of delivery Month Day Year
ds, P.O.	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director, After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detach.	by	Part II. Other significant conditions co	entributing to death bu	it not resulting in the	e underlying cause gi	ven in Part I.			ntribute to the cause of death? 3 □ Probably 4 🗹 Unknown
Division of Vital Records,	ysician: The law re is certificate has be director, page 2 sh	Completed						24a. Was autoj perfo 1 Yes	psy ormed?	. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
Vital	ysician: The s certificate director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	nt 2 ☐ ER/Outpat	Oth	er:	ck only one) Home 5 \square Resid	dence 6 \(\text{Ot} \)	hor/Specify)
on of	ending Physeath. or: After this the funeral di	Certificate: 1	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation	28a. Date of injury (Month, Day,	28b. Time	of 28c. Injur	y at	28d. Describe h		
Divisi	Hospital or Atten 24 hours after deat Funeral Director: stely filled in by the		3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur building, etc.				City or Tov	vn, State)	ber or Rural Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral Attention to the funeral Attention by the funeral Attention filled in by the funeral Attention	- Medical	29a. Certifier (Check 2 Medical Examironly one) 3 Certifying Nursi	ician: To the best of n ner: On the basis of ex e Practitioner: To the	amination and/or inve	estigation, in my opinio	on, death occurred the time, date and	at the time, date a	and place, and d the cause(s) and	ue to the cause(s) and manner stated manner as stated.
	E S E S C T	1	Hemm	Hu	Den	J 039	064		MAN	ed (Month, Day, Year) LIT 19 2:12
			30. Name and address of person who co	omple ed cause of de	ath (Item 23a) (Type	, Print) 18111		hilip Dr MD 20832		

State Registrar

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Ma\ch 19. 2012 Mary Helen Cecelia FELDMAN 9:00 A M Medical a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery 7051 Carroll Avenue #611 Takoma Park If Under 1 Year | If Under 24 Hrs Months | Days | Hours | Min. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours 447-12-2001 91 **Director** 1 - M 2X F July 21, 1920 0klahoma Usual Residence of Deceden ms 23a or 28a-f show must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits the Maryland Director Takoma Park 1 Yes 2 No Maryland Montgomery 10e. Street and Numbe 10g. Citizen of What Country? Funeral within 72 hours after death with 20912 United States 7051 Carroll Avenue #611 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Examiner Arroed Forces

1 Yes 2

If Yes, Give Black, , White, etc. white "natural", or 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Year or Dates. WW II 3 Widowed 4 X Divorced Specify: Completed r than "natur the Medical B 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) the Trinity College Head of Library Science 27 is marked other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ည Doris Earl Nave Fabian Earl Kearney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 s ment of Health a Steve Feldman, Son 27 2009 Oglethorpe St., #101, Hyattsville, MD 20a. Method of Disposition
1 ☐ Burial 2 🏿 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or oth 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 03/20/12 Alexandria, VA of F (era) Service icensee Torchinsky Hebrew Funeral Home 20012 254 Carroll St., NW, Washington, DC 23a. Part 1. Enter the disease, or complications aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Respiratory Failure Phylician. Medical resulting in death) Due to (or as a consequence of): **Examiner** Myocardial Infarction Some distribution of the sa Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical as the bu Division of Vital Records, P.O. Box 68760 use 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
 5 Other (specify) ę in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 X No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 certificate has performed? Yes 2 No 1 🗌 Yes 2 🗆 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 X No Hospital Other: ၉ 1 Inpatient 2 I ER/Outpatient 3 -4 ☐ Nursing Home 5 🗶 Residence 6 ☐ Other (Specify) this Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 5 Pending s after death. Accident 1 Yes 2 No Investigation the Suicide 6 Could not be 3 ☐ Suiciue 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by

State

completely

within 2. the

Hospital 24 hours a Funeral !

2

Medical

29a. Certifier

29b. Signature and the of certifier

Teresa Allen, M.D.,

31. Date filed (Month, Day, Year) MAR 21 2012

determined

2. Registrar's Sign

ss of person who completed cause of death (Item 23a) (Type, Print) Allen, M.D., 6525 Belcrest Road, Suite 160, Hyattsville, MD

🔏 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D00347

-20-2012

29c. License number

2-02202		Please Type or Print in E						jible		
ene David Flor	es	_			of Health and Men	tal Hygi	ene		201	2 1008
		1- For State Registrar	Ce	rtificate	of Death			g. No.	201	
Physicia		Decedent's Name (First, Middle,Last)				1 1	Date of Deat Month	Day	Year	3. Time of Death 0745 hrs
edical Exami	ner	RENE DAVID 4a. Facility Name (if not institution, give street and number	FLOR	ES	4b. City, Town, or Location of		larch 17,		County of Death	
		Washington Adventist Hospital	3 1)		Takoma Park	or Death			ontgomery	
Funeral-			Age (In yrs. I	ast birthday		er 24Hrs. 8.	Date of Birt		D/YYYY) 9. Birt	hplace (State or
Director					Months Days Hours	_			Foreig	n
		220-11-4036 1X M 2 F Usual Residence of Decedent	28		Yrs.		FEB.	13,.	1984	untry)WASH. D.C
80 y		10a. State 10b. County	10c. City	Town or L	ocation					10d. Inside City Limits
	'n	MD. PRINCE GEORGES			BRENTWOOD					1 X Yes 2 No
Maryland 28a-f show d at ooce.	Director	10e. Street and Number		_	10f. Zip Code		10	g. Citiz	en of What Cour	itry?
death with the Maryland or items 23a or 28a-f sho must be ootified at ooce	O.	3822 ALLISON ST.			20722				U.S.A	
with the ms 23a be coti	ral	11. Marital Status 12. Was Decede		.S. 13.	Was Decedent of Hispanic Orig			. 1	4. Race - Ameri	can Indian, Black,
death r ite	Funeral	1 Never Married 2 Married 1 Yes	2 X No		If Yes, specify Cuban, Mexican	, Puerto Rica	an, etc.)		White, etc.	
15-0036 filed within 72 hours after death with the Maryland al Hygiene. ed other thas "natural", or items 23a or 28a-f she t, the Medical Examiner must be sotified at ooce		Widowed 4 Divorced If Yes, Give Year or Dates:			Yes 2 No specify:					SPANIC
hours	ed	15. Decedent's Education (Specify only highest grade of			dent's Usual Occupation (Give g most of working life. DO NOT		done	16b. Ki	ind of Business/I	ndustry
36 in 72	plet	Elementary/Secondary (0-12) College (1-4 o	or 5+)							DENIMAT CAR
with with giene	Completed by	12 17. Father's Name (First, Middle, Last)]	PORTOR 18 Mother	's Name (Fin	st Middle M			RENTAL CAR
Hilled Hy	Be C	RENE FLORE	7.C		TO.INOTHO!					
21215-0036 Muld be filed within 7 Mental Hygiene. marked other thao	To B	19a. Informant's Name/Relationship (Type, Print)	20	19b. Ma	illing Address (Street and Num	TERES			CEVEDO y or Town, State,	Zip Code)
MD d 2 sho lih and in 27 is	٦	TERESA FLORES/MOTHER		382	2 ALLISON ST.,	BRENT	WOOD.	MD.	20722	
		20a. Method of Disposition		Place of Dis	sposition (Name of cemetery, r other place)	Da			ocation - City or	Town, State
Baltimore, permit. Pages 1 an Department of Hee Important: I itee		1 X Burial 2 Cremation 3 X Removal from 5	Jiaio	•	VET CEMETERY	2 2/.	2012	T.7 A G	THE MOTION	D C
nit. Partme		4 Donation 5 Other Specify: 21. Signature of Funeral Septifice Licenses	MI			3-24-			SHINGTON	
Balt permit. Departu Import injury		W.W. Chamberson	9 MOO	091	2. Name and Address of Facility CHAMBERS FUNER 5801 CLEVELAND	AL HOM	E & C. RIVE	REM/ RDAI	ATORIUM, .E. MD.	P.A. 20737
Physician		23a. Part I. Enter the disease, or complications that cause								Approximate Interval
/Medical		failure. List only one cause on each line. Immediate Cause (Final disease a. Pulmonary Th	romboem	bolism						Between Onset and Death
Examiner		or condition resulting in death) Due to (or as a con								
	L	Sequentially list conditions, b.		6)						
	i	if any, leading to immediate Due to (or as a concause. Enter Underlying Cause	isequence o	π):						
-D :=	Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a con	sequence o	f):						
and Cecuted	삤	d								
be ex sician urial		UNPENDED AMENDED								
of Vital Records, P.O. Box 68760, iog Physician: The law requires that the death certificate be exafter this certificate has been signed by the attending physician funeral director, page 2 should be detached for use as the burial	Physician/Medio	IF FEMALE: 23b. Was decedent pregnant in the	ome of preg	nancy					Date of delivery	
certification and ing	ciar	past 12 months?	at time of de	eath 5	Fetal death 3 Ectopic Other (Specify)	pregnancy		'	Month D	ay Year
BOy death	ysi	1 Yes 2 No 9 Unknown 9 Unknown		•	Other (opeary)					
at the		Part ii. Other significant conditions contributing to dea	ath but not re	esulting in t	ne underlying cause given in Pa	rt I.	23e. Did tol	bacco u	se contribute to t	he cause of death?
res th signe be de	d b	Obesity					1 Yes	2 🗌	No 3 Prob	ably 4 🗹 Unknown
rds requi	Completed						24a. Was a			opsy findings available empletion of cause of
eco re law te has ge 2 s	틹				_		perform	ned?	death?	
Tiffica or, pa	ပ္	25. Was case referred to medical			26.Place of Death ((Check only			10	2 140
/ita	Ö	examiner? 1 ✓ Yes 2 No	tient 2 🗸	ER/Outpat	Tou -	Nursing Ho		Residen	ce 6 Other	
Division of Vital Records, P.O. ral or Atteodiog Physician: The law requires that the rape death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detactly	-	27. Manner of Death 28a. Date of Ir	njury (Yaar)	28b. Time	of Injury 28c. Injury et Work	? 28d	Describe h	ow injur	y occurred	
	흲	Natural 5 Pending	,1 aai)		1 Yes 2	No				
ViSi or Att her de birect in by	fica	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of	Injury - At he	ome, farm, s	street, factory, office building, etc	c. 28f.			d Number or Rur	al Route Number, City
Dien Oital of Tilled	Certification:	4 Homicide determined (Specify)					or Town, St	ate)		
Hos 24 hc Fuo		29a. Certifier 1 Certifying Physician: To the best of		-						
Division of Vital To the Hospital or Atteoding Physician: within 24 hours after death. To the Fuorral Director: After this certif completely filled in by the funeral director.	Medical	one) 2 Medical Examiner: On the basis of examiner and manner stated		nd/or invest	igation, in my opinion, death oc	curred at the	time, date a	ind plac	e, and due to the	cause(s)
	Ž	29b. Signature and title of certifier			29c. License number				ate signed (Mon	th, Day, Year)
2		Mellen Broull, Me	\rightarrow		O.C.M.E.			Marc	h 18, 2012	
	ľ	30. Name and address of person who completed cause of								
					W. Baltimore Street, Ba	altimore, I	MD 2122	3		
			rar's Signatu	ire San	Ked					
Regist	ēΪ	MAR 22 2012 Serves	1 19.	17-					-	

COME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<u>012</u> Month Physician/ 8:54pm 15 <u>Jeffrey Madison Ferrell</u> March Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Montgomery Rockville 8. Date of Birth (Month, Day, Y Social Security Number 6. Sex Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days Hours 1960 Director 51 Maryland 220-76-8144 Usual Residence of Decedent show 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State notified at Director 1 Yes 2 X No 28a-1 Gaithersburg Maryland | Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō : If item 27 is marked other than "natural", or items 23a o or other traumatic event, the Medical Examiner must be Funeral 20877 227 Rolling Road United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 X Never Married 2 Married 1 Yes If Yes, Give 2 XNo should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) d Mental Hygiene. marked other tha Photography Photographer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Charles Madison Ferrell Donnie Sue Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 227 Rolling Road, Gaithersburg, MD 20877 f Health Donnie Sue Ferrell (Mother) 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or ot ☐ Burial 2 👿 Cremation 3 ☐ Removal from State Metropolitan Crematory 3/17/12 Alexandria, Virginia 4 Donation 5 Other (Specify) 22. Name and Address of Facility DeVol Funeral Home 10 Fast Deer Park Drive Gaithersburg, MD 20877 21. Signature of Funeral Service Lice 3a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final infavoti on myocardio Physician/ disease or condition resulting in death) Medical Due to (or is a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate
Cause (Disease or linjury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): ed by the attending physician detached for use as the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an tor: After this certificate has the funeral director, page 2 s autopsy performed? Yes 2 2 No 1 Yes 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 FER/Outpatient 3 IDOA မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 🔀 Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0 and address of person who completed cause of death (Item 23a) (Type, Print) 30. Name 9901 Medical Center Drive, Podoville, Mamland

DHMH 17 Rev 7/2009

State Registrar filed (Month, Day, Year)

A 425 # 15: 8018

PERRALL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🎧 For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Marthch 100, 2012 Physician/ Farrah Eftidad 2:30p M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Byron House Potomac 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. al Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours 578-58-6508 100 9/24/1911 Lebanon **Director** 1 □ M 2 1 F Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Montgomery MD Silver Spring 1 Yes 2X No 5 10e. Street and Number 10g. Citizen of What Country? 23a Funeral 20902 10604 Malone Street USA or items death 12. Was Decedent Ever in U.S Armed Forces? . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Completed by 1 Never Married 2 Married 2 X No 72 hours after 1 Yes lif Yes, Give Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: "natural", 3

Widowed 4 □ Divorced Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) than " Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. Restaurant Owner/Operator 8 marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name *(First, Middle, Maiden Surname)* Marsha Shahadi ပ Constantine Shahadi 19a. Informant's Name/Relationship (Type, Print)
Marvann Schenkel/daughter permit. Page 1 and 2 shou Department of Health and Important: If item 27 is m any injury or other traums 19b. Mailing Address Street and Number of Bural Boute Milling Rock VIIIe, Md. 20853 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) 3/16/2012 Silver Spring, Md of Heaven PHILIPAD RINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring,Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physiciani Arrhythmia disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) that the death certificate be executed Cause (Disease of Injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 phy use as ding IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Month Year Pregnant at time of death
Unknown 1 Yes 2 No 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ The law requires dementia, hypertension, diabetes meelitus Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of autopsy perform death? 1 Yes 2X No 1 Yes Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Yes 2 🔀 No 4 ☐ Nursing Home 5 ☐ Residence 6 🗷 Other (Specifassisted မ 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After t living work?
1 Yes 2 No 1 X Natural 5 Pending injury within 24 hours after death.

To the Funeral Director; A completely filled in by the fu Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signatura 29c. License number 29d. Date signed (Month, Day, Year March 15,2012 D42518 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

Gul Chablani MD

1 9 2012

31. Date filed (Month, Day, Year,

32. Registrar's Signature

19785 Crystal Rock Dr. #310 Germantown, Md

for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Physician/ Joseph Farrell March Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery 0 Social Security Number 7. Age (In vrs. last hirthday If Under 1 Year If Under 24 Hrs. 8 Date of Birth Funeral 1 **X** M 2 □ F Hours 15,1937 Scotland 3 **Director** August 151-32-4744 Usual Residence of Decedent show 10a. State 10b. County at 10c. City. Town or Location Director notified 28a-f Maryland Montgomery Montgomery Village 10e. Street and Number ö 10f, Zip Code 10q. Citizen of What Country? the Medical Examiner must be Funeral items 23a 10632 Wayridge Drive 20886 United States 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ö þ 1 Never Married 2 Married 1 ★ Yes 2 No If Yes, Give Year or Dates. Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Caucasian "natural", 3 X Widowed 4 Divorced Completed 1963-65 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. is marked other than life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Biomedical Research Engineer Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည James Farrell Agnes Service traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Melissa Evans, Daughter 10632 Wayridge Drive, Montgomery Village, MD 20886 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date**UKN** 1 X Burial 2 ☐ Cremation 3 X Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Piscataway, New Jersey Resurrection Burial Pk 21. Signature of Figneral Service Licenses 22. Name and Address of Facility Simple Tribute Kowe 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition . Medical resulting in death) Examiner Sequentially list conditions Examine cause. Enter Underlying ascular diseas and -transit Cause (Disease or iinjury that initiated events Due to (or as a consequence resulting in death) Last physiciar Physician/Medical that the death certificate be Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, MN9 to 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an has autopsy performe Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Yes 2 **X** No 잍 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at work? 28d. Describe how injury occurred Natural Accident 5 Pending 1 🗌 Yes 2 🗌 No Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours a

To the Funeral Completed filled Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check xaminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Narse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

9:05 P

10d. Inside City Limits

Onset and Death

1 🗆 Yes 2 ื No

9. Birthplace (State or Foreign

2012

Black, White, etc.

Month

death?

29d. Date signed (Month

1 Yes

Day

24b. Were autopsy findings available prior to completion of cause of

12

2 🗌 No

State Registrar

10

29b. Signature and til

30. Name and address of pe

31. Date filed (Month, Day,

Heshmat MD

MAR 2 7 2012

who completed cause of death (Item 23a) (Type, Print)

2401

120057574

Research Bird Stet 330 Rockvill

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ 2012 12:50p M Irvin Paul Greenbaum March Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Casey House Rockville Montgomeru Social Security Number 8. Date of Birth (Month, Dav. Year) 9. Birthplace (State or Foreign . Age (In yrs. last birthday) **Funeral** Months Hours 579-18-0287 Director 1 X M 2 D F 87 Yrs. 12/09/1924 Maryland Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits the Maryland Director notified Silver Spring 1 Yes 2 X No Maryland Montgomery 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 must be by Funeral 23a 8045 Newell Street, #118 20910 U.S.A. Health and Mental Hygiene. tem 27 is marked other than "natural", or items other traumatic event, the Medical Examiner mu permit. Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married X Yes Baltimore, Maryland 21215-0036 1 Yes 2 K No Specify. Completed 3 X Widowed 4 Divorced WWII White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Real Estate Real Estate Developer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Sadie Harris Jack Greenbaum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2723 Ontario Road, NW. Washington, DC 20009 Jackie Greenbaum - Daughter other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date Department of H Important: If ite any injury or ot 1 XI Burial 2 Cremation 3 XI Removal from State King David Mem. Grdns 03/18/2012 | Falls Church, Virginia 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. MD 20904 11800 New Hampshire Ave., Silver Spring, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ Pneumonia disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director, After this certificate has been signed by the attending physician and that initiated events resulting in death) Last Due to (or as a consequence of): within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 4 Pregnant Other (specify) Day Pregnant at time of death 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 X No ၉ 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 X Other (Specify) Hospice 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 Yes 2 No Certificate: 28d. Describe how injury occurred injury 1 X Natural 5 Pending Investigation Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined

2 10+1

> State Registrar

Medical

29a. Certifier

only one)

M.D., 1355 Piccard Drive, #100, Rockville, Maryland 20850 Geoffrey Coleman,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D37142

29d. Date signed (Month, Day, Year)

March 16, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 19 2012 March Yolanda L. Garcia 5:50 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Genesis Healthcare Rockville Montgomery If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** Days (Month, Day, Year) 86 Yrs **Director** 217-96-2759 1 □ M 2 🕱 F Oct. 7, 1925 Guatemala Usual Residence of Decedent or 28a-f show notified at 10b. County 10c. City, Town or Location the Maryland 10a. State 10d. Inside City Limits Director Maryland | Montgomery Gaithersburg 1 Yes 2 X No 9 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a with 381 Westside Drive, #302 20878 Guatemala items within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. ò þ 1 Never Married 2 Married Yes 2 X No 1 X Yes 2 □ No Specify: Guatemalan Maryland 21215-0036 If Yes, Give Year or Dates "natural", Specify. 3 Widowed 4 Divorced Completed White Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working Il Hygiene. I **other than** ' life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the 12 Cook Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Menta Important. If item 27 is marked: any injury or other traumations once. and Mental is marked o 2 Alfonso Rivas Antonia Solis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lucia Torres (Daughter) 913 Bayridge Terrace, Gaithersburg, Maryland 20878 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State March^{Date}23 2012 Rockville, Maryland 22. Name and Address of Facility DeVol Funeral Home, Signature of Funeral Service Licensee 10 East Deer Park Drive, Gaithersburg, MD 20877 Muchan 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician Cardiovascular Sudden Death disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Hypertension Sequentially list conditions, Examine Due to lor as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physiciar Physician/Medical that the death certificate be P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?

1 Yes 2 X No Month Day Year detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Atrial Fibrillation, Cerebrovascular Disease; Division of Vital Records, 1 Tes 2 No 3 Probably 4 M Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? Hyperlipidemia, Colon Cancer 24a. Was an page 2 s autopsy perform After this certificate 2 No Yes 2X No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 X No Other: 4 X Nursing Home 5 Residence 6 Other (Specify) ပ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 X Natural 5 Pending Accident Investigation filled in by the 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

31. Date filed (Month, Day, Year,

MAR 22 2012

Tao Yu, M.D., 15245 Shady Grove Road, #130, Rockville, Maryland 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

82. Registrar's Sign

D69800

March 20, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ALVIN MARCH AMES 10 PM 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner MONITGOMERY NASHINGTON ADVENTIST PARIL AKomA HOSPITAL Birthplace (State or Foreign Country) Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 **Funeral** Months Hours Min 578-62-2753 1 M 2 D F **Director** 60 Sept. 24 1951 Washington, DC 28a-f show at 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director Wash.,DC must be notified 1 Yes 2 X No Washington, 10e. Street and Numbe ò 10g. Citizen of What Country? Funeral 23a 20009 1803 Biltmore Street, N.W. Apt. United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Armed Forces?

1 Yes 2 X No
If Yes, Give Black, White, etc. 9 þ 1 Never Married 2 Married within 72 hours after 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 Divorced Specify: "natural", Completed Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Activist Politics Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 7 is marked o ၉ Mary Teresa Kirwan Patrick Joseph Galvin permit. Page 1 and 2 should I Department of Health and Me Important: If item 27 is mari 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16 Mt. Hygeia Road, Foster, RI 02825 Jeffrey Galvin/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of Important: If it any injury or o once, ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crem. 03/21/2012 Alexandria, VA Signature of Funeral Service Licensee DeVol Funeral Home 22. Name and Address of Facility 10 E. Deer Park Drive, Gaithersburg, MD 20877 MO1202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ PANCREATOBIU ART METASTATIC disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last and Due to (or as a consequence of) the burial attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 use as t IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ Live Birth 2 Fetal death jo in the past 12 months?

1 Yes 2 No Month Year Day Pregnant at time of death signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has performed? Yes 2 No 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 No မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director, After this 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 1 Tes 2 No the Accident Investigation 3 Suicide
4 Homicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined Medical 🖟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 06-2011

Hegistral AAR 24

BERNICE

31. Date filed (Month, Day, Year)

Paudon

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A1000

KILRETON

6905

CARROLL

MARCH 20

TAKOMA PARK, MD 20912

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** GREENBERG 02 3 20A M MARVIN 20 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Levindale Hebrew Geriatric Hospital Baltimore City Baltimore If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Min (Month Pay / 1922 1 X M 2 □ F Washington, DC 577-28-9544 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or Items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 XNo Directo Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20903 901 Devere Drive u.s.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No 1942 − If Yes, Give Year or Dates: 1945 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify Specify: þ 3 X Widowed 4 ☐ Divorced White Completed Is marked other than "natu aumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Civil Engineer WSSC 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental Samuel Greenberg Marie Haber ို 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marco E. Greenberg - Son 15 Wetherbee Court, Phoenix, Maryland 21131 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages
Department of t
Important: If Its
any Injury or or
once. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Ft. Lincoln Cemetery 03/30/3012 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Licensee 1232 11800 New Hampshire Ave., Silver Spring, MD 20904 26a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
5 WWYTHS Immediate Cause (Final THRIVE FAILURG Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 4 yours MULTI INFARCT DEWENTIA Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Accidents cay s Levebrovascular that initiated events resulting in death) Last and Due to (or as a consequence of): P.O. Box 68760 physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) □Yes 2□No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but net resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, fibrillation 1 Yes 2 No 3 Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 No To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 1 Natural 5 ☐ Pending investigation 1 Yes 2 No after death.

I Director: /
d in by the fi 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di completely filled in 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 030377 WW March 20, 2012 2+1

State Registrar 31. Date filed (Month, Day, Year)

M.

MAR 26 2012

RUBBRIT

2012 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PARK HEIGHTS AVE BALT MOZIZIS

Please Type or Print in Black Indouble Ink Ensure All Copies Are Legible.

amend #5,18620b Per FH G926ck Indouble Ink Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month Physician/ March 13 2012 5:20 A Medical Sirlene Green 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 211 Redland Blvd **Rockville** Montgomery Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) If Under If Under 24 Hrs. 8. Date of Birth **Funeral** Months 579-70-8667 Hours (Month, Dav. Year) Director 1 □ M 2 🕱 F 61 Feb. 24, 1951Washington, D.C. Usual Re show 10b. County 10c. City, Town or Location at 10a. State Director notified 28a-f 1 Yes 2 X No Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be 23a Funeral 211 Redland Blvd 20850 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates. ò ģ 1 X Never Married 2 Married Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene.

ent. If item 27 is marked other than "natural", or altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: African-American 3 Widowed 4 Divorced Completed Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working I Hygiene.
I other than " life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 11 Food Preparation Worker **Grocery Store** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental F 27 is marked of traumatic ever မ Lettie Elizabeth Markum unknown-Shade A. Green 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1500 SW Pleasantview Drive P267, Gresham, OR 97080 Antoinette Green, daughter other t 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 4/11/2012 👿 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) # 5 Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) 3/23/2012 Rockville, Maryland Parklawn Cemetery 21. Signature of Funeral Service Licenses MO1102 Simple Tribute Kowe 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Dnset and Death** Physician/ Lung Cancer disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of P or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) attending physician Physician/Medical Box 68760 the use as IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No for Month Day Year 5 Other (specify) ed by the a P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>6</u> 1 X Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy this certificate has ral director, page 2 Yes 2 No Division of Vital 25. Was case referred to medica 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA the funeral 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After 5 Pending injury X Natural Accident Investigation 6 ☐ Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: Dn the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆

State Registrar

MAR 1 5 2012

Nelson G. N. Kalil, 31. Date filed (Month, Day, Year)

only one) 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D51616

29d. Date signed (Month. Day, Year)

March 14, 2012

State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Towanda Valencia Givens 03 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** St. Thomas More Ayattsville MD If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Hours 10-17-1958 578-84-2610 **Director** 53 1 □ M 2 🗓 F Usual Residence of Decedent permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he matical at 10a, State 10b. County 10c. City, Town or Location Director DC Washington DC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4231 Blagden ave. N.W. 20011 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Force þ 1 Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 Widowed 4 X Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Supervisor *l*aste management Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Robert Lee Givens Valerie Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robin Given Banks -sister Blagden ave.N.W. WA. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) <u>Chesapeake</u> 03 - 13 - 1221. Signature of Funeral Service Licersee 22. Name and Address of Facility W.H. Bacon Funeral home INC Wangle Dacore 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final espiratory Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) pur line Due to (or as a consequence of): resulting in death) Last attending physiciar Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Obenly To the Hospital or Attending Physician: The law requires t within 24 hours after death. To the Funeral Director: After this certificate has been sign Division of Vital Records, Completed taputuna 24a. Was an 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA the Funeral Director: After this maletely filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be

23d. Date of delivery Month Day 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy Yes 2 4 Nursing Home 5 Residence 6 Other (Specify, 28d. Describe how injury occurred Accident
Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year, 2006 3681 Q012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ajit Kurup, M.D. 1835 University Blvd-E #208; Hyattsville, MD 20783 . Registrar's Signa ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

3. Time of Death

2:30 and

9. Birthplace (State or Foreign

Washington DC

10d. Inside City Limits

1X Yes 2 □ No

Year 12

14. Race - American Indian.

Black

Beltsville MD

Approximate Interval Between

Onset and Death

Black, White, etc.

DC 20011

13

P.G.

US

4c. County of Death

Registrar DHMH 17 Rev 06-2011

State

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death ^{Day} 2012 Physician/ March 13, Andrew Joseph Girolami **a**M 6:17 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 12819 Bluet Lane Silver Spring Montgomery . Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthdav) 8 Date of Birth Birthplace (State or Foreign Country) Funeral Days Hours Min (Month, Day, Year) 577-16-0066 1 🗷 M 2 🗆 F Director 91 Jan. 25, 1921 PA Usual Residence of Decedent 28a-f shov 10a, State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 X No MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 12819 Bluet Lane 20906 USA death v 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or 1 Never Married 2XX Married þ 1x Yes If Yes, Give 2 🗌 No 72 hours after Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☒ No Specify. Completed 3 Widowed 4 Divorced Year or Dates. 1942-45 traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Engineer Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ္ဂ Paulo Girolami Luisa Maggenti 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau James Girolami/Son 9110 Seven Locks Road, Bethesda, MD 20817 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State March 16, 2012 Gate of Heaven Cemetery 4 Donation 5 Other (Specify) Silver Spring, MD 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring. 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph_sician/ Ventricular Dysrhythmia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Hypertensive Heart Disease 10 yrs cequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Hypertension 10 yrs Due to (or as a consequence of): resulting in death) Last Physician/Medical pni Division of Vital Records, P.O. Box 68760 the attending ph IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Pregnant at time of death 1 Yes 2 2 signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Cerebrovascular Disease 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a Was an autopsy performed prior to completion of cause of page certificate 1 Yes 2 No 2 🛣 No Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 Tes 2 🔀 No ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) work? 1 ☐ Yes 2 ☐ No 1 X Natural 5 Pending М Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best/of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) + 2 ĺ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10401 bld Georgetown Road, Bethesda, MD 20814 Joel Goozh, MD 31. Date filed (Month, Day, Year)

State

Registrar

MAR 15 2012

P.0. To the Hospital or Attending n 24 hours area ne Funeral Director: Afte moletely filled in by the fur Division

29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D19400 March 16,2012 cour

3. Time of Death

1431

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

Day

28f, Location (Street and Number or Rural Route Number

City or Town, State)

Year

1 Yes 2 No

El Salvador

White

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

344 University Blvd.West #211 Silver Spring,md Ernesto Africano MD

Registrar

Medical

31. Date filed (Month, Day, Year MAR 19 2012

4 Homicide

determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 4:20 pm Charles Goodman 2012 March Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Sandy Spring Montgomery Brooke Grove Rehab & Nursing Center 9. Birthplace (State or Foreign Country) New York Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Hours 1 1 M 2 □ F 110-09-5983 01/22/1916 Director 96 Usual Residence of Decedent r 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Sandy Spring 1 Yes 2 No Maryland Montgomery 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? ıral", or items 23a or Examiner must be Funeral U.S.A. 20860 18131 Slade School Road 12. Was Decedent Ever in U.S.
Armed Forces?

1 12 Yes 2 No 1941If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. δ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 X Widowed 4 Divorced Specify: White Completed 1969 Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Lieutenant Colonel U.S. Army Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H
fitem 27 is marked ot
r other traumatic ever ဂ္ Jeanette Rose Glazier Page 1 and 2 should be Benjamin Joseph Goodman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia F. Goodman - Daughter 28 Crosswood Court, Burtonsville, Maryland 20866 Department of Healt Important: If item 2 any injury or other t Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 🗓 Burial 2 🗆 Cremation 3 💆 Removal from State Arlington Natl. Cem. | 05/22/2012 | Arlington, Virginia 4 Denation 5 Other (Specify) Sign 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwe Immediate Cause (Final Ph, sician BOWEL 24 HOURS ACWIE TNEARCTION disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that initiated events Due to (or as a consequence of) resulting in death) Last ed by the attending physician detached for use as the burial Physician/Medical The law requires that the death certificate be IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Melliters Division of Vital Records, Diabetes sate has been sig page 2 should b 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No To the Hospital or Attending Physician; within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, to 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 No Accident Investigation 2 Accider
3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

State

12+1

Registrar

only one

29b. Signature and title



30. Name and address of person who completed cause of death (Item 23a) (Type, Print

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D33700

29d. Date signed (Month, Day, Year)

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Goffredi 2012 Year Jeannette Gilbert March 16, 3:45 ам 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Montgomery Holy Cross Hospital Silver Spring If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthdav) 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) Hours 577-14-9938 1 🗆 M 2 🔀 F 96 April 5, 1915 DC Usual Residence of Deceden 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MD Silver Spring Montgomery 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 201 Williamsburg Drive USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. White 1 Never Married 2 Married 1 ☐ Yes 2 No Specify If Yes, Give Year or Dates 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 4 Office Manager Communications 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Carroll Gilbert Frankie Bel1 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9908 Edgehill Lane, Silver Spring, MD 20901 Mary Jo McNamara/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) March 2012 Gate of Heaven Cemetery Silver Spring,MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses Francis Agres Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring,MD 20901 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Sepsis disease or condition resulting in death) Due to (or as a consequence of): Respiratory Failure Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

Ph. sician/ Medical **Examiner**

Physician/

Medical

Director

Funeral

ρ

Completed

Be

ည

Examiner

Funeral

Director

28a-f shov

ò ms 23a or must be r

"natural"

I Hygiene.

of the and Mental Hygie 27 is marked other traumatic event, to

Department of Health are Important: If item 27 is any injury or other trace

the Medical

notified

death with the Maryland

Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after

> and burial attending physician use as the for ed by the at detached for been signed by t should be detach has page 2 certificate funeral director, this within 24 hours after death.
>
> N To the Funeral Director: After

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. δ Renal Failure Completed 24a. Was an autopsy performed? Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🛛 No ည 1 Yes 1 KMnpatient 2 - ER/Outpatient 3 - DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 5 Pending 1 Natural injury 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D69288 March 16, 2011

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

use of death (Item 23a) (Type, Print) 1500 Forest Glen Road, Silver Spring, MD 20910 30. Name and address of person who completed cause Yodit Negussie, MD 1

State Registrar

filled in by the

completely

5

Medical

31. Date filed (Month, Day, Year) **WAR 19 2012** 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ Month Year :00 March JNI 101 2012 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Ders WOSH: N Birthplace (State or Foreign Country) If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday) **Funeral Director** 220-28-6190 1 🗶 M 2 🗆 F 77 Sept. 9 1934 Washington DC Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 ☐ Yes 2 🕅 No <u> Maryland | Washington</u> Hagerstown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ò by Funeral 23a 16913 Longfellow Court 21740 USA items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status the Medical Examiner Black, White, etc. 1 Yes 2 No ö 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White "natural", 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Fire Department Fire Fighter Be event 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) nd Mental I ၉ Ith and Ments 27 is marked traumatic e Hunter P. Heltzel, Sr. Katheryn Ralston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 16913 Longfellow Court, Hagerstown, Md. 21740 Scott Heltzel - Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place. 1 Burial 2 X Cremation 3 Removal from State Hagerstown, Maryland 4 Donation 5 Other (Specify) permit. Minnich Funeral Home Signature of Funeral Service Licenses 22. Name and Address of Facility 415 E. Wilson Blvd. Hagerstown, Maryland 21740 Za 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each, line. Approximate Interval Between Onset and Death Immediate Cause (Final Reno Acule Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine (or as a consequence of) Due t if any, leading to immediate PREUMONIA that initiated events Due to (or as a consequence of): resulting in death) Last as the burial Completed by Physician/Medical Box 68760 attending IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ ò in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No ed by the a g Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause 23e Did tobacco use contribute to the cause of death? CARNOMYOPOTHIN 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been significant page 2 should b Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perforte or Attending Physician: The Yes 1 🗌 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) **Division of Vital** Hospital: Other: မ Inpatient 2 DER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) filled in by the funeral Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No Investigation Accident within 24 hours after deatl To the Funeral Director. Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JM-10+1 RESSOWN M 1050

Registrar

DHMH 17 Rev 06-2011

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For AMEND#19B per FH 1 - State Registrar 3/13/12 AACO HEALIH DEPT. CMH Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 20 T2 11:30A M Viola Hamilton Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore Washington Medical Center Anne Arundel Glen Burnie 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days 212-34-3525 **Director** 1 □ M 2**X** F Feb 10 1934 78 Yrs Maryland 28a-f shov death with the Maryland 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits Director notified Mary1and Anne Arundel Gambrills 1 ☐ Yes 2 X No 10e Street and Number 10f. Zip Code ō 10g. Citizen of What Country? items 23a or ner must be r Funeral Rte 3 South 1068 Md. 21054 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or i þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. 3altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: 3X Widowed 4 □ Divorced Black 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 27 is marked other than r traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) 12th Home Health Aide Prince George's Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ William Shorter Sr Annie Chisley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) #### 3 South Gambrills, Md. Eva Wilson(Daughter) 21054 1068 Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State Department of F Important: If ite any injury or ot once. 1 X Burial 2 Cremation 3 Removal from State St. John AME Zion 3 - 13 - 12Odenton, Md. 4 ☐ Donation 5 ☐ Other (Specify) Miname a Roses of Scilit Sons Mortuary, P.A. 21. Signature of Funeral Service Licensee Larry 1922 Forest Dr. Annapolis, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final AWIE MYOCARDIAL Physician/ INFARCTION disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** MILO VASWUM DISPASE MERLIOSCUPIOTIC Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) ng physician and as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Year Day 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HYPOGLYCEMIA 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law autopsy performed Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☑ No Other: မ 1 Inpatient 2 FR/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manney of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending injury 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number) 4 Homicide determined building, etc. (Specify) 24 hours a Medical 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year) D21776 MARCH 7, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MUY, PASADENA, MD 21122 RITCHIE MUMBAND 8021

Registrar

DHMH 17 Rev 06-2011

State

istrar's Signature

3 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 10 MARC 20 Medical 4c. County of Death Anne Arundel 4a. Facility Name (if not institution, give street and number, **Examiner** , or Location of Death Millersville Assisted Living Well Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 208-18-8795 July 18, 90 **Director** T921 Pennsylvania 1 □ M 2 🔀 F Yrs or 28a-f show notified at 10c. City, Town or Location 10d, Inside City Limits Director Anne Arundel Annapolis Maryland 1 Yes 2 X No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code items 23a or ner must be n 21403 3734 Thomas Point Road Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. 6 þ 1 Never Married 2 Married White 1 ☐ Yes 2X No Specify: Specify: "natural" **¾**Widowed 4 □ Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Hair and Beauty Cosmetician 11 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Zaharo George and Mental F is marked o t. Page 1 and 2 should be fill trent of Health and Mental tant: If item 27 is marked or Demetrios Koukoulis traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3734 Thomas Point Road Annapolis, Maryland 19a. Informant's Name/Relationship (Type, Print) 21403 Elaine Harvan/daughter Department of Health Important: If item 2: any injury or other tonce. other i 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗆 Burial 2 🛛 Cremation 3 🗀 Removal from State 3/13/2012 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Crematory Baltimore, Maryland 21. Signature of Funeral Se 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. en each line. nterval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical certificate be the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent preg 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 month Month Day Year Pregnant at time of death 1 ☐ Yes 2 ■ 9 ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ The law requires Completed 1 Yes 2 No 3 Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed certificate Yes To the Hospital or Attending Physician: funeral director, 25. Was case referred to predica Be 26. Place of Death (Check only one. Assis de Other: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of s after death. I Director: After the 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending 1 Yes 2 No filled in by the 2 Accident
3 Suicide
4 Homicide Accident Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certi

State Registrar

Maryland 21215-0036

Baltimore,

Box 68760

of Vital Records,

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day KEWANA OLEA HARPS-WALKER 11-20 B Medical 3/17/2012 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville 170 Talbott St., #108 Montgomery If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** MD ountry) Hours Min. 1 M 2 XF 6/5/1985 Director 26 219-17-4832 Usual Residence of Decedent show iral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1

Yes 2 □ No Rockville MD Montgomery 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20852 death Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes If Yes, Give Maryland 21215-0036 hours after 1 ☐ Yes 2 🙀 No Specify: and Mental Hygiene. is marked other than "natural", 3 Widowed 4 Divorced Year or Dates Black mit. Page 1 and 2 should be filed within 72 hours vartment of Health and Mental Hygiene. ordant: If item 27 is marked other than "natur injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Security 12th Security/Allied Barton Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Victoria Posey Kwame Harps, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) #108, Rockville, MD 20852 Anthony Walker/busband 70 Talbott St.. Baltimore, . Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) 3/30/2012 | Silver Spring, MD of Heaven ure of Funeral Septide Licenses 22. Name and Address of Facility Snowden Funeral Home Washington Street, Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph. sician/ disease or condition resulting in death) Glioblastoma Multiform Medical Examiner Pulmonary Embolision

Due to (or as a consequence of): Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events ician and e burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last physician s the burial Medical Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery 3X Ectopic pregnancy the past 12 months?
Yes 2 \sum No 5 Other (specify) Pregnant at time of death ed by the a Unknown 9 Unknown P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 🙀 No 3 ☐ Probably 4 ☐ Unknown Completed has been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No page After this certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 1 Tyes 2 😾 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1X Natural 5 Pending injury work?
1 Yes 2 No within 24 hours after death.

To the Funeral Director: After Completed filled in by the fun death. 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number
D 0064024 29d. Date signed (Month, Day, Year) 12012

Registrar

State

31. Date filed (Month, Day, Year

LACHTCHININA, M.D

7600 Carroll Avenue,

'TakomaPark, MD 20912

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 1 per dr. 9926,04/25/2012dhb
State of Maryland / Department of Health and Mental Hygiene 2 0 2

State Amend Item 25 per me, g926,04/17/2012dhb
Registrar

Reg. No. 1. Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Anna Mae Humphrey Month Physician/ 1837 02 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Montgomery 01ney Medstar Montgomery Medical Center 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Davs Min (Month, Day, Year) 577-56-1669 Director 1 D M 2 Yrs. 0 7/20/1942 Washington, DC Usual Residence of Decede 28a-f show 10a. State 10b. County 10c, City, Town or Location with the Maryland Director Examiner must be notified 1 Yes 2 No MD Brookeville Montgomery 10f Zin Code ō 10e. Street and Numbe 10g, Citizen of What Country? "natural", or items 23a Funeral 20833 USA 1510 Brighton Dam Road death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Black, White, e 1 Never Married 2X Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed 3 Divorced 4 Divorced other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic exercise. Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ Madge C. McKenny Harry S. Heflin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1510 Brighton Dam Road, Brookeville, MD 20833 Hugh R. Humphrey/Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔲 Burial Cremy cemetery, crematory or other place) March 15, 2012 fon 3 🗆 Removi Alexandria, VA Metropolitan Crematory 4 Donation 5 🗀 21. Signature of Tuneral ዮንያስመርያያ ^{Adjress} ሮሪቴፒኒስs Funeral Home Inc. 500 University Blvd. W., Silver Spring,MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Hemorhage tracanial Medical resulting in death) Examiner Sequentially list conditions, if any hocing immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine 2 APPROVED BY MEDICAL EXAMINER Due to (or as a consequence of): resulting in death) Last buri Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death

9 Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy Year Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 High Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 Ves 2 100 To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) of Vital examiner? 1 **X** Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ပ 1 Inpatient 2 R/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural 5 Pending Division 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be within 24 hours after deat To the Funeral Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 0050410 who completed cause of death (Item 23a) (Type, Print) 18101 Prace Philip D-, Clary 20853 Michae 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mae G. Holtzman 2072 6:25p M March Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Rockville Casey House Montgomery Social Security Number If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) **Funeral** Days **Director** 058-28-9424 1 🗆 M 2 🗶 F 99 02/19/1913 New York Usual Residence of Decedent 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Chevy Chase Maryland Montgomery 1 Yes 2 K No 10e. Street and Number õ 10f. Zip Code 10g. Citizen of What Country? pe Funeral "natural", or items 23a 20815 8100 Connecticut Avenue, #1024 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 X No
If Yes, Give
Year or Dates. à 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify Completed 3 X Widowed 4 Divorced Specify. Caucasian er than "natur , the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) n and Mental Hygien

7 is marked other tl
raumatic event, th Bookkeeper Textiles Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, 2 Israel Gress Jenny Feldman : If item 27 is marke or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joy Ann Adler - Daughter 8906 Honeybee Lane, Bethesda, Maruland 20817 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place F 1 $\fbox{3}$ Burial 2 \square Cremation 3 \square Removal from State Department of Important: If any injury or once. Judean Mem. Gardens 03/25/2012 Olney, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Signature of Funeral Service Licenses |11800 New Hampshire Ave.,Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Colon Cancer disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). and Due to (or as a consequence of): resulting in death) Last physician the buris Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 for use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Pregnant at time of death 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy perform death? of or Attending Physician: The after death.

Director: After this certificate by 2 **X** No 1 Yes Yes funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) Other: 2 X No 1 Yes မ 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) Hospice 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending injury work?
1 Yes 2 No the 1 Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) To the Hospital o within 24 hours af To the Funeral Di Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signat re and title of certifle 29d. Date signed (Month, Day, Year, IS R143201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 6001 Muncaster Mill Road, Rockville, Maryland 20850

CRNP.

Debrah Miller.

MAR 26 2012

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Otto Gregory Vincent Hamilton 2012 March 10. 2:12 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 7570 Elioak Terrace Gaithersburg Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral Director** 283 44 8200 1 **X**] M 2 □ F 62 October 9. 1949 Illinois Usual Residence of Decedent aţ 0a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ems 23a or 28a-f sh r must be notified a 1 Yes 2 No Montgomery Maruland Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral u.s.A. 1510 Elioak Terrace 20879 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No If Yes, Give ☐ U.o. + No ıral", or iten I Examiner n Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ρ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Specify: American-1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Year or Dates. Vietnam Indian traumatic event, the Medical 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. Montgomery County Elementary/Secondary (0-12) College (1-4 or 5+) After School Program Scheduler Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 7 is marked ဂ္ Otto Vincent Lillie Mae Harvin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s f Health item 27 Clara Louise Hamilton. Spouse 7570 Elioak Terrace, Gaithersburg, MD 20879 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o ō 1 Durial 2 Cremation 3 Removal from State 4 ☐ Donation 5 🕱 Other (Speciftintombment ParklawnMemorialPark 03/16/2012 Rockville. Maryland 11800 New Hampshire Ave., Silver 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Months Immediate Cause (Final Ph_sician/ Lung Cancer Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical the bur Division of Vital Records, P.O. Box 68760 as t IF FEMALE: nse 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day ed by the a 9 Unknown been signed k should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 🗓 No 3 🗆 Probably 4 🗆 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify 27. Manner of Death nours after death.

neral Director: After the filled in by the funera 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town. State) 4 Homicide determined within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practition or To the local of my included, death occurred at the time, date and close to the cause(s) and manner stated. 29a. Certifier To the 9b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D54378 March 12, 2012 e of death (Item 23a) (Type, Print) Cheryl Aylesworth, M.D. 30. Name and address of person who completed car

Registrar
DHMH 17 Rev 06-2011

2730 University Boulevard,

31. Date filed (Month, Day, Year) NAR 14 2012

Suite 400. Wheaton. MD 20902

West,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 558 CM HOOK sloria 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Johns LIT U Hospita Baltimore HOP KINS If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Hours Min (Month, Day, Year) 579-46-2110 1 🗆 M 2 🔀 F **Director** 80 Usual Residence of Decedent 11/7/1931 DC 28a-f shov items 23a or 28a-f sho ner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Bowie Prince Georges 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8115 Gold Cup Lane 20715 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, the Medical Examiner Black, White, etc. ō ģ 1 Never Married 2 Married 1 ☐ Yes 2 🖈 No If Yes, Give Year or Dates. Maryland 21215-0036 1 Yes 2 No Specify. "natural", 3 Widowed 4 Divorced Specify: Completed Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Private Industry other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ permit. Page 1 and 2 should be Department of Health and Ment. Important: If item 27 is marked any injury or out. Robert Demus Green Johness Holmes d Number of Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 81 Mailing Addre BOWIE, Glory Carr/Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 3/14/2013 Hanover, MD Ardent Cremation Funeral Service Licer 22. Name and Address of Facility Latimore Funeral Services, P.A. 2818 E. Baltimore Street, Baltimore MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Endocarditis disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner 5 Sequentially list conditions, Examine Due to (or as a consequence or). if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events and To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last physician s the buria Physician/Medical Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 5 Other (specify) 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? à Division of Vital Records, 1 Yes 2 No 3 Probably 4 Ninknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Tes Yes æ 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work within 24 hours after death.

To the Funeral Director: Aft
completely filled in by the fu 1 Yes 2 No Investigation Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Name Practitioner: To the best of my knowledge 29b. Signature and title of certifier/ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

wolfe Street Battimore

400 North

21287

MO

hatter

31. Date filed (Month, Dav. Year)

MAR 15 2012

86

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 20^{Year} Michael George Hutchins March 4:45 A M 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 7916 Oxfarm Court Prince Georges Bowie Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Days Hours 285-54-5974 Usual Residence of Decedent 1 XM 2 F 56 5/16/1955 DC 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 ☐ No MD Prince Georges Bowie 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 7916 Oxfarm Court 20715 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2X Married 1 ☐ Yes 2 ☐ No If Yes, Give 1 ☐ Yes 2 XNo Specify: 3 Divorced 4 Divorced Specify: Black Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12th Police Officer Federal 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Bilal Ruth Green 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 910 Drum Ave. Capitol Heights, MD 20743 <u> Aishah M. Bilal/Sister</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State Ft. Lincoln 3/20/2012 Brentwood, MD Donation 5 Other (Specify) 22 87 8 d Address & Family Latimore Funeral Services 2287 8 d E. Baltimore St. Funeral Services Signature of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death disease or condition resulting in death) Plasma Cell Leukemia months Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Fctopic pregnancy in the past 12 months? 5 Other (specify) Month Pregnant at time of death Dav Year 2 No g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 😾 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 Yes 2 No 26. Place of Death (Check only one) Hospital Other: 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 K Residence 6 ☐ Other (Specify

Examiner and To the Hospital or Attending Physician: The law requires that the death certificate be executed physician s the buria Division of Vital Records, P.O. Box 68760 the red signed by the

page 2 s ate has

after death.

Director: After this certific
In by the funeral director,

filled in by

cal

Physician/

Medical

Examiner

Funeral

Director

28a-f show

ō

death

Baltimore, Maryland 21215-0036

item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be

I Hygiene.

should be filed with and Mental Hygier.

. Page 1 and 2 sh ment of Health a tant: If item 27 is

Department of Important: If it any injury or o

Physician/

Medical

notified at

Director

Funeral

by

Completed

Be

မ

Exami Physician/Medical Completed by Be မ Certificate:

25. Was case referred to medical examiner? 2X No 1 Tes

27. Manner of Death Natural 5 Pending Accident Suicide 4 Homicide

Investigation 6 Could not be determined

28a. Date of injury (Month, Day, Year)

28b. Time of M 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at work? 1 Yes 2 No

D26250

28f. Location (Street and Number or Rural Route Number, City or Town, State)

3/16/2012

28d. Describe how injury occurred

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occur (Check 2 Medical Examiner: On the basis of examination and/or investigation	red at the time, date and place, and due to the	cause(s) and manner as stated.
(Check 2 ☐ Medical Examiner: On the basis of examination and/or investigation only one) 3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death	n, in my opinion, death occurred at the time, date n occurred at the time, date and place, and due to	and place, and due to the cause(s) and manner stated the cause(s) and manner as stated.
29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

<u>Matilda So,</u> MD 221 <u>Mercantile</u> Lane Largo, MD 20774 31. Date filed (Month, Day, Year)

Registrar

Fun Dire

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show

Physic /Med Exam

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: A rer this certificate has been signed by the attending physician and

		For AMEND#10c, 1 State Registra AMEND#1per	LOf,+170er	INF,3/28	3/125	BMW MoCo Certificate	of Deat	n and Me Th	ntai Hyg	iene eg. No.	2010	2 10107
		Decedent's Name (First, Midd						2.	Date of Deat	h	- 0 1 1	3. Time of Death
Physicia Medic		Elma Lillenh			/ 1. 1.	паттеп		M	Month arch 1.	5, Day 2(012 Year	10:40 a ^M
Examin		4a. Facility Name (If not institution	on, give street and nu	ımber)		4b. City, Tow		on of Death		T	ounty of Deat	th
	d	Brooke Grove	Nursing	& Rehab	. Ct		y Spr			Mot	ntgome	
uneral irector		5. Social Security Number 570–34–7809	6. Sex 1 M 2 F	7. Age (In yrs. I	ast birthe Yr	Months Da		der 24 Hrs. 8. s Min. Ju	Date of Birth (Month, Day, une 5,	Year) 1921	9. Birl	thplace (State or Foreign ountry) ND
*		Usual Residence of Decedent 10a. State 10b. Count	v	10c. City	/. Town o	or Location						10d. Inside City Limits
-f sho	ρ	MD Mo	ontgomery	San	dy S	pring						1 ☐ Yes 21⁄€ No
r 28a	Director	10e. Street and Number	onegomery		0111	10f. Zip Cor	860		1	0g. Citize	n of What Co	l ountry?
23a o	a	1637 Hickory	Kno11			-20	832	-	Ť	1	USA	
coportions of the party managed of the framework of the party of the party of the party of other traumatic event, the Modical Examination of the party of other traumatic event, the Modical Examination of the party of other traumatic event, the Modical Examination of the party o	by Funeral I	11. Marital Status 1 □ Never Married 2 □ Ma 3 ☑ Widowed 4 □ Divorce	Armed Fo	2]∑ No ive	S.	13. Was Decedent If Yes, specify (Suban, Mexic	can, Puerto Ric	y Yes or No- an, etc.)	1	. Race - Ame Black, White White pecify;	e etc
than "natur re Medical I	Completed	15. Decede (Specify only high Elementary/Secondary (0-12)	ent's Education est grade completed)		((Decedent's Usual Oc Give kind of work do ife. DO NOT use re memaker	ne during m	nost of working			of Business	•
other ent, I	Be C	17. Father's Name (First, Middle		4	110	memaker	18. Mo	other's Name (F	First, Middle, N			
rked c	0 B	Andreas E. Li					M	aria Th	eodors	on		
trauma		19a. Informant's Name/Relation John Hallen/Se				Mailing Address (St.				•		Zip Code)
item		20a. Method of Disposition	<u> </u>	20b. P	lace of D	isposition (Name o	F	Date	9 :		tion - City or	Town, State
rtant: If njury or		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other ((Specify)	State Arl	Ingt	crematory or other on Nation Cemetery		June 20	12		ngton,	
lmpo any l		21. Signature of Funeral Service	e Licensee	ale	->	Francis 500 Univ	J. Co. ersit	î ^{ll} ins F y Blvd.	uneral .W, S	Home ilve	e Inc.	ng, MD 20901
		23a. Part 1. En er the disease, of shock, or heart failure. Lis	or complications that of	caused the death	n. Do no	t enter the mode of	dying, such	as cardiac or r	espiratory arre	est,		Approximate Interval Between
sician		Immediate Cause (Final disease or condition resulting in death)	a. Ass	PIRATIO	N	FUELLING	AINC					Onset and Death 3 DAYS
edical ıminer		resulting in death)		(or as a consequ		:						
	Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	D.	SPHAGI		ř –						
transit	Examiner	that initiated events	· -	JANKER		SENILE	DI	EWEN	ri A			
physician and sthe burial transit	dical Ex	resulting in death) Last	d.	(or as a consequ	ience of)); 						
ng phy as th	a)	IS SSAAN S										
certificate has been signed by the attending rector, page 2 should be detached for use as	hysician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	1 Live	itcome of pregna birth 2 Fetal gnant at time of d nown	death	3 ☐ Ectopic pregr 5 ☐ Other (specif				23	d. Date of de Month	livery Day Year
igned b	by Pł	Part II. Other significant condit	tions contributing to d	leath but not resu	ılting in t	he underlying cause	given in Pa	irt I.	23e. Did tot	acco use	contribute to	o the cause of death?
een s						• •			1 🗆 Ye	s 2 🗆	No 3□ P	robably 4 Unknown
cate has b , page 2 sh	Completed								24a. Was a autops perforr 1 □ Yes	ned?		utopsy findings available completion of cause of s
certif	Be	25. Was case referred to medic examiner?	Hospital:			<u> </u>	0.11	ace of Death (
er this eral di	.To	1 Yes 2 No 27. Manner of Death	28a. Date		ER/Outp 28b. Tir	ne of 28c.	njury at	Nursing Home	5 Reside			ecify)
: A Te	atio.	1 Natural 5 Pendi 2 Accident invest		nth, Day, Year)	Inju	ury	Nork? 1 ∐Yes 2			,,		
Director	ertification:	3 ☐ Suicide 6 ☐ Could	mined 28e. Place	e of Injury - At ho ling, etc. <i>(Specif</i>)	me, farm	n, street, factory, off	ce	28f	f. Location (St City or Town		Number or R	tural Route Number,
To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical C	29a. Certifier 1 Certify (Check only one) 2 Medica	ring Physician: To the at Examiner: On the l and mar	e best of my kno basis of examina nner stated.	wledge, tion and/	death occurred at the for investigation, in	ne time, date my opinion,	e and place, an death occurred	d due to the c at the time, d	ause(s) a ate and p	and manner a place, and du	as stated. e to the cause(s)
To th	Me	29b. Signature and title of cortifi	ier	7		29c. Lie	ense numbe	er	2	9d. Date	signed (Mon	th, Day, Year)
10		1994	ame v	N)	00	$ \mathcal{D} $	337	00	1	MAR	KH 15	5,2012
		30. Name and address of person	YOU'E M	D 1	54	ype, Print) N. Av	TIZA	4N 5	7, W	1261	MSP	ORT, MD
Sta Registr		31. Date filed (Month, Day, Year MAR 2 0		Registrar's Signa	ture	aske						·

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

12-02132	Please Type or Print in Black Indelible Ink. Ensure All Copi	ies Are Legible.			
Michael Glen Harper	State of Maryland / Department of Health and Mental H	Hygiene	201	0 101	0
1- For State Registrar	Certificate of Death	Reg. No.	201	2 101	U
Physician/ 1. Decedent		Dete of Death Month Day	Year	3. Time of Death	

Funeral Director 5. Social Security Number 433-70-6451 S. Married S. Sex T. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. S. Date of Birth(MM/DI Days Hours Min. July 11, 19 Usual Residence of Decedent 10b. County 10c. City, Town or Location MD Montgomery Rockv111e 10e. Street and Number 10f. Zip Code 10g. Citize 10g. Citize	3. Time of Death 1420 hrs County of Death ontgomery DYYYYY) 9. Birthplace (State or Foreign Country) LA 10d. Inside City Limits 1 Yes 2 X No
4a. Facility Name (if not institution, give street and number) 16500 Emory Lane 5. Social Security Number 433-70-6451 Usual Residence of Decedent 10a. State 10b. County 4b. City, Town, or Location of Death Rockville 4c. City Rockville 4b. City, Town, or Location of Death Rockville 4c. City Rockville	County of Death ontgomery 9. Birthplace (State or Foreign Country) LA 10d. Inside City Limits 1 Yes 2 No
Funeral Director 5. Social Security Number 433-70-6451 Usual Residence of Decedent 10a. State 10b. County 7. Age (In yrs. last birthday) 6. Sex 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 8. Date of Birth(MM/DI July 11, 19	9.50 Sirthplace (State or Foreign Country) LA
Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10c. City, Town or Location	Foreign Country) LA 10d. Inside City Limits 1 Yes 2 No
10a. State 10b. County 10c. City, Town or Location	1 Yes 2 X No
MD Montgomery Rockv111e 10e. Street and Number 10f. Zip Code 10f. Zip Code 10g. Citize 11g. Marital Status 11g. Was Decedent Ever in U.S. 11g. Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.)	
10e. Street and Number 10f. Zip Code 10f. Zip Code 10g. Citize 10g	en of What Country?
11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. 1 Never Married 2 Married 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 1 X Yes 2 No	
3 Widowed 4 Divorced If Yes, Give Year 1972-92 1 Yes 2X No specify:	4. Race - American Indian, Black, White, etc. SpecifyWhite
15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	nd of Business/Industry
Standary (0-12) College (1-4 or 5+) Physician Med	dical
To plan and the pl	Surname)
Joseph Norwell Harper September 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City	v or Town State Zin Code)
19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City 19b. Mailing Address (Street and Number or Rural Route Number, City 16500 Emory Lane, Rockville, MD 2	
19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City 19b. Mailing Address (Street and Number or Rural Route Number, City 19b. Mailing Address (Street and Number or Rural Route Number, City 19b. Mailing Address (Street and Number or Rural Route Number, City 19b. Mailing Address (Street and Number or Rural Route Number, City 19c. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City 10c. Local Route Number, City 20c. Method of Disposition 1	ocation - City or Town, State
201. Metrod of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility Francis J. Collins Funeral Home State 1 Source Ligensee 1 Source Ligensee 22. Name and Address of Facility 23. Name and Address of Facility 24. Signature of Funeral Home State 25. Francis J. Collins Funeral Home State 25. Francis J. Collins Funeral Home State 26. Francis J. Collins Funeral Home State 27. Name and Address of Facility 28. Francis J. Collins Funeral Home State 29. Name and Address of Facility	exandria, VA
1500 University Bivd. W., Sliv	er Spring, MD 2090.
failure. List only one cause on each line.	Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) Let a consequence of the	
Sequentially list conditions, if any, leading to immediate b. Hanging Due to (or es e consequence of):	
cause. Enter Underlying Cause C. Due to (or as a consequence of):	
events resulting in death) Last d. UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome of pregnancy 23d.	
To perform the past 12 months? 23c. If yes, outcome of pregnancy 1	Date of delivery Month Day Year
23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy No past 12 months? 1 Yes 2 No 9 Unknown 1 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use 1 Yes 2	se contribute to the cause of death? No 3 Probably 4 Unknown
1	24b. Were autopsy findings available
The law requires the past of	prior to completion of cause of death?
Yes 2 No 25. Was case referred to medical examiner? Hospital: Inspital:	1 Yes 2 No
25. Was case referred to medical examiner? 1 Yes 2 No 28. Pilot of Death (Check Only Onle) 1 Yes 2 No 29. Pilot of Death (Check Only Onle)	
27. Manner of Death 28a. Date of Injury FOUND: 28b. Time of Injury FOUND: 28c. Injury at Work? Subject found hanged by the control of the	
The standard of the standard o	nd Number or Rural Route Number, City
3 Suicide 6 Could not be determined (Specify) Dettached garage or Town, State) 16500 Emory Lane, I 292 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and	
29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and place and manner stated. 29b. Signature and title of certifier 29d. Discovered at the time, date and place and manner stated.	
250. Eleanse names	Date signed (Month, Day, Year)
30. Name and address of person who completed cause of death (Item 23a)	ch 15, 2012
Ana Rubio MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	
State 31. Date filed (Month, Day, Year). Registrar AR 1 9 2012	

DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra AMEND#5 per INF, 3/26/12; BMW, MoCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death .Day 2012 Physician/ March 7 10:53 a M Dorothy Hamilton Medical Μ. 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Annapolis Anne Arundel Medical Center If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth Hours Min. (Month, Day, Year) **Director** 1 M 2 XF 86 1925 24. Louisiana 28a-f shov or items 23a or 28a-f shorminer must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo 1 Yes 2 No MD Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1817 Plymouth Court United States 20716 filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, er than "natural", or iter the Medical Examiner Black, White, etc. þ 1 Never Married 2 Married 1 Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 X Widowed 4 Divorced Specify: Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Deputy Clerk County of Los Angeles Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fis marked o ၉ Lyles Fred Rose Mamie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 1817 Plymouth Court, Bowie, MD 20716 <u>Mark Hamilton, son</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 X Removal from State 4 Donation 5 Other (Specify) Holy Cross Cemetery | 03/17/2012 | Culver City, CA 21. Sign, turn of Funeral Service Livenser 22. Name and Address of Facility Hines-Rinaldi Funeral Home, MU0709 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feature. List only one cause on each line. Immediate Cause (Final Onset and Death Phynician/ SEPSIS disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner BACTERENIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events E P Due to (or as a consequence of) resulting in death) Last attending physiciar Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 as the IF FEMALE: asn 23b. Was decedent pregnant 23d. Date of delivery st 12 months? in the past 12 Month Day Year g 🗌 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ SEUERE HEART FAILURE, ESRO, CUA, CHF Division of Vital Records, Completed 1 Yes 2 Xo 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?

1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at work?
1 Yes 2 No 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending within 24 hours after death

To the Funeral Director: /
completely filled in by the Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier 📈 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 072199 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

K. PATŁU 2001 Medical PArhw

State Registrar 31. Date filed (Month, Day, Year)

MAR 14 201

Medical Parkway Annopolis, mol

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No.

Reg. No. For State Registrar Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MARCH 2012 14 12:49 P M DORIS M. HARRISON Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner TALBOT EASTON WILLIAM HILL MANOR 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min. 1 □ M 2 🗓 0971971927 218-24-4834 MARYLAND 84 **Director** Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be matter at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No TALBOT EASTON MD10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 501 DUTCHMANS LANE 21601 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Force Black, White, etc. ģ 1 Never Married 2 Married 2 🔀 No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: WHITE Completed 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ WALTER H. GARDNER BETTIE E. COLLINS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROSE ANN CONNER / DAUGHTER P.O. BOX 174 HILLSBORO, MD 21641 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date CHESAPEARE CREMATION 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 03/15/2012 STEVENSVILLE, MD CENTER FELLOWS, HELFENBEIN & NEWNAM FUNERAL 200 SOUTH HARRISON STREET EASTON, MD 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician. disease or condition Medical resulting in death) Due to (or as a cons Examiner Sequentially list conditions, if any, leading to immediate Physician/Medical Examiner Due to (or as a consequence of) CETTALCATION APPROVED BY MEDICAL EXAMINER attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE s, outcome of pregnancy Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death Unknown signed by the Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> allure 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page 2 this certificate 2 🗌 No 1 Yes Yes 2 25. Was case referred to medical director, 26. Place of Death (Check only one) Be examiner? 1X Yes Hospital: Other: Certificate: To 1 Inpatient 2 I ER/Outpatient 3 I DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death.

To the Funeral Director: After 5 Pending Natoral work? Fall while walking 03/05/2012 2300 2 🗶 No 2 X Accident Investigation \mathbf{p}^{M} the 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number City or Town, State) 501 Dutchmans ane, Easton, MD Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide filled in by determined Home Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of 29c. License number 29d, Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

31. Date filed (Month

APR 0

nwood

Gas to

MK

Registrar's Signa

2/60

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2012 Year Dolly Homi Irani March 18 6:30 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Olney Montgomery General Hospital Montgomery If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Davs (Month, Day, Year) 219-94-4141 Director 1 🗆 M 2 💢 F 85 Yrs India Jan 1, 1927 Usual Residence of Decedent show 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f MD Rockville 1 Yes 2 No Montgomery 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? ems 23a or r must be r Funeral 708 Glenmore Avenue. #D24 20850 USA items ; filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. permit. Page 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: Asian Indian 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4 or 5+) Elderly Care Live-in Companion Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Khushro Irani unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12007 Ashley Drive, Rockville, MD 20852 Shera Behram, daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Memorial Park: 3/21/2012 Rockville, Maryland 21. Signatury of Funeral Service Dicensee 22. Name and Address of Facility Simple Tribute M01102 Kowt 1040 Rockville Pike, Rockville, MD 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause an each line. Approximate Interval Between Immediate Cause (Final Onset and Death 4theroscleroti Physician/ ardio Vascular disease or condition Medical resulting in death) **Examiner** Graphically list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Exami for use as the burial-transit attending physician and Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Dav Year Pregnant at time of death signed by the at d be detached fo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director; After this certificate has 1 Yes 2 No completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \(\text{\text{Nursing Home}} \) 1 Residence 6 \(\text{\text{Other}} \) Other (Specify) _2 🗆 No ျ 1 Inpatient 2 KER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Vatural 5 Pending work?
1 Yes 2 No Accident Investigation 6 Could not be Suicide 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Check 3 [only one) 29b. Signature and title of certifier 29c. License number 29d Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) med stur montgomery medical center Phyllis Nicholson, MD 18101 Prince Phillip Drive Olney, Mary

DHMH 17 Rev 06-2011

Registrar

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3 Time of Death Physician/ 2012 0440 Raymond W. Ihndris Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Montgomery Rockville If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs, last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) Months Days Hours Min. 265-18-076.4 91 Director 1 🛛 M 2 🗆 F 4-1-1920 Indiana Usual Residence of Deced 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location notified at rector 1 Yes 2 No MD Gaithersburg Montgomery ä 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? other traumatic event, the Medical Examiner must be Funeral items 23a 20882 United States 24337 Hilton Place 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian 11. Marital Status rmed Forces?

X Yes 2 \sum No WWII If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc 5 þ 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE "natural", 3 XWidowed 4 Divorced Completed Year or Dates Raymond 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business/Industry life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+ Medical Research Chemist and Mental Hygie Is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Veda "UNKNOWN" Will Ihndris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ihndris, Important: If item 27 any injury or other tra 24337 Hilton Place, Gaithersburg, Maryland 20882 SON Raymond L. Ihndris 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date of 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 3-17-12 Falls Church, Virginia National Crematory 21. Signature of Funeral Service_Licensee 22. Name and Address of Facility Edward Sagel Danzansky-Goldberg M00910 1170 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Septic Physician/ Shoch disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** resistant stach aureus bacterenia Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events P Exami renal Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) Pregnant at time of death Yes 2 No 9 Unknown the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown or Attending Physician: The law requires Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed has page 2 certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 2 No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this funeral 27. Manner of Death Natural 28c. Injury at 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 5 Pending work?
1 Yes 2 No Accident Investigation 6 Could not be filled in by the Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Receeled 31121 71323 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 Medical Car Dr Ruckville, MD 20850 Nsha MD Yeniqalla 31. Date filed (Month, Day, Year) State MAR 2 0 2012 Registrar

084

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			101	epartment of Health and I Certificate of Death	Mental Hygie	0010	10113
	Physicia		Decedent's Name (First, Middle, Last) Michael Jones		Date of Death Month	Day Year	3. Time of Death 8:05 P M
5	Medic Examin		4a. Facility Name (if not institution, give street and number) WRNMMC	4b. City, Town, or Location of Death Bethesda		4c. County of Death Montgomery	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthout 1 M 2 F 68 Yr 1 M 2 F 68 Yr	Months Days Hours Min.	8. Date of Birth (Month, Day, Yes 07/22/19	ar) Count	
	yland -f show ed at	ctor	10a. State 10b. County 10c. City, Town of		•	1	0d. Inside City Limits
	the Mar or 28a e notifi	Funeral Director	MD Montgomery Betheso	10f. Zip Code	10g	. Citizen of What Coun	1 X Yes 2 □ No try?
	ns 23a must b	nera	5000 Battery Lane Apt. 702	20814		nited State	es
920	be filed within 72 hours after death with the Maryland ental Hygiene. Ked other than "natural", or items 23a or 28a-f show ic event, the Medical Examiner must be notified at	by	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ▼ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 □ No 1978 − If Yes, Give Year or Dates.	 Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto Yes 2 No Specify: 	ecify Yes or No- Rican, etc.)	14. Race - America Black, White, e Specify: Whit	etc.
Baltimore, Maryland 21215-0036	nin 72 hour ne. .han "natu e Medical	Completed	(Specify only highest grade completed) (C	ecedent's Usual Occupation live kind of work done during most of work e. DO NOT use retired)	ing 16	b. Kind of Business/Inc	dustry
d 21	lled with Hygier other t ent, th	Be	17. Father's Name (First, Middle, Last)	geon / Cardiology	ne (First, Middle, Maid	Medicine den Sumame)	
ylan	uld be fi Mental Marked Natic ev	은	Stanley Jones	Nancy 1	Maloney		
Mai	at and 2 should be file of Health and Mental F fitem 27 is marked of r other traumatic ever		I I	Mailing Address (Street and Number or Rur Bayside Terr. Rive:			
ore,	ge 1 and tof Hea tritem or othe		20a. Method of Disposition 20b. Place of D	isposition (Name of	Date 200	c. Location - City or To	wn, State
altim	permit. Page Department of Important: If any injury or once.	-	4 Donation 5 Other (Specify)	22. Name and Address of Facility Jos		r's Sons I	
ñ	Der Imp		Williamy R, Engy	5130 Wisconsin Ave	e. NW Wash		
. P	hysician/		23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final METRA CITATION COLLA		or respiratory arrest,		Approximate Interval Between Onset and Death
ž	Medical Examiner		disease or condition resulting in death) A. METASTATIC SQUE Due to (or as a consequence of):	MOUS CELL CANCER			
		ner	Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying				
	be executed sician and burial and	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events c. resulting in death) Last Due to (or as a consequence of):				
	e be exi ysician ie burial	dical E	d.				
09/89	cerrificate nding phy use as the		IF FEMALE: 23b. Was decedent program: 23c. If yes, outcome of pregnancy				
Box	death he atte ied for	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1	3		23d. Date of delive Month	Day Year
JS, P.O.	law requires that the has been signed by tl e 2 should be detach	by	Part II. Other significant conditions contributing to death but not resulting in t	he underlying cause given in Part I.		co use contribute to th	
ğ,	The law recate has been page 2 sho	Completed			24a. Was an autopsy performed 1 Yes 2 🗓	prior to cor death?	osy findings available mpletion of cause of 2 No
Vital	sician: certific	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outp	26. Place of Death (Chec		0 7 04 - (0 : (1)	
01	ng Pny fter this uneral c	ate: To	27. Manner of Death 1 ☒ Natural 5 ☐ Pending 1 ☒ Natural 5 ☐ Pending	e of 28c. Injury at	28d. Describe how in	e 6 Other (Specify) njury occurred	
DIVISION OF	Attendi r death cctor: A by the f	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At home, farm	M 1 ☐ Yes 2 ☐ No , street, factory, office	28f. Location (Street	t and Number or Rural	Route Number,
2	ortal or ours afte rral Dire		building, etc. (Specify)		City or Town, Si		
:	of the hospital of Attending Physician: In the Day hours after death. To the Transfal Director, After this certification properties of the properties of th	Medical	29a. Certifier (Check children in the post of my knowledge, de children in the post of my knowledge in the post of my knowle	vestigation, in my opinion, death occurred a	it the time, date and p	lace, and due to the cau	ise(s) and manner stated.
	with vith		29b. Signature and title of certifier	29c, License number MD64164		Date signed (Month, Elarch 16, 2	
				RNMMC, Bethesda, MI	20889-56	00	
	Stat Registra		31. Date filed (Month, Day, Year) 33. Registrar's Signature	ales			
	negistra	11	MAR 21 2012 Seture A. A.				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene **1 –** For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 03 Day 02 Year 12 Physician/ 2207 M SAMUEL B JOYCE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A BALTIMURE UNIVERSITY OF MARYLAND MEDICAL CENTER 8. Date of Birth (Month, Day, Ye May 23 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 220-56-9821 **Director** 1 **X** M 2 □ F Maryland 59 Yrs. 1952 Usual Residence of Decedent 28a-f shov 10c. City, Town or Location 10d. Inside City Limits aţ 10a. State rector er than "natural", or items 23a or 28a-fs the Medical Examiner must be notified Maryland Anne Arundel Annapolis 1 ☐ Yes 2X No Ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1800 C Copeland St. 21401 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status rmed Forces?

X Yes 2 \quad No Black, White, etc. 1 Never Married 2X Married þ Maryland 21215-0036 Specify: Black 1 Yes 2X No Specify: If Yes, Give Year or Dates 1971-73 3 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "ı The Capital life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Truck Driver Newspaper 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) မ Samuel B. Joyce Sr Pearl Moulden traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh
Department of Health ar
Important: If item 27 is
any injury or other trau 1800 C Copeland St. Annapolis, Md. 21401 Rachel M. Joyce (Wife) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 3-14-12 Crownsville, Md. Maryland Veteran 4 ☐ Donation 5 ☐ Other (Specify) Miname are see facilitisons Mortuary, P.A. 21. Signature of Funeral Service Licenses 1922 Forest Dr. Annapolis, Md. 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician ARTERIAL GAS EMBOLI disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner MULTI-DRGAN Sequentially list conditions if any, leading to immediate cause. Enter Underlying Examir Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical that the death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by HYPOTENSION, GAP METABOLIC 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, ACIDOSIS Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy page 2 this certificate or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 No 1 Inpatient 2 ည ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 24 hours after death.

Funeral Director: After injury 1X Natural 5 \square Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Hospital Medical 1 🗶 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 within 24 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) 03/02 P27357 30. Name and address of person who complete cause of death (Item 23a) (Type, Print) GREENE ST. BALTIMORE, MD 21201 S. NADER

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Mon:

strar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death 3/16/2012 Day Physician/ 21:50^M PATRICIA ANN JUSTICE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Suburban Hospital Bethesda, MD If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 6. Sex **Funeral** (Month, Day, Year) Director 50-04-6796 1 M 2 XF 59 2/22/1953 South Carolina Usual Residence of Decedent show 10c. City, Town or Location 10d Inside City Limits ms 23a or 28a-f sho must be notified at 10a. State 10b County within 72 hours after death with the Maryland Director 1

Yes 2 □ No MD Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12400 Great Park Circle, #104 USA 20876 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🔀 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc 0 þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify Specify: "natural", Completed 3 Widowed 4 Divorced **Black** other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. other than " Elementary/Secondary (0-12) College (1-4 or 5+) 12th Self-Employed/Daycare Childcare Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, nd Mental marked ၉ Ida Mae Myers Theodore Justice and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 12400 Great Park Circle, #104, Germantown, MD 20876 Teresa Justice/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of harmonic of harmonic life ite any injury or other Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 3/23/2012 Silver Spring, MD Heaven Snowden Funeral Home Signature of Funeral Service Licensee 22. Name and Address of Facility 246 N. Washington St., Rockville, MD 20850 1015 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) <u>Gasterointestina</u>1 bleeding Medical Due to (or as a consequence of Examiner Liver Cancer Sequentially list conditions, it is a sequentially list conditions, cause. Enter Underlying Physician/Medical Examiner Due to lor as a consequence of Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physiciar use as the bur that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 No 9 Unknown by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician: The law requires within 24 hours after death. 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy performed? Yes 2 🔀 No 1 Yes 2 No of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 Yes 2 X No မ 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After (Month, Day, Year) injury 1 X Natural 5 Pendina Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, completely filled in by 4 Homicide determined building, etc. (Specify) City or Town, State, Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3/10/12 Justice, Patricia

> State Registrar

29b. Signature and title of cer

Saved Elsayyad,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10110 Molecular Dr.

29c. License number

D0062435

Suite 206, Rockville, MD 20850

29d Date signed (Month, Day, Year)

3/17/2012

for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 22, 2012 5:26 P March Royce Dixon Jordan, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Suburban Hospital Bethesda Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Funeral Social Security Number Months Hours Min **Director** 252-17-1826 1 X M 2 🗆 F 48 May 17, 1963 Decatur, Georgia Usual Residence of Deced show 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director must be notified 28a-f 1 Tes 2 No Maryland Chevy Chase Montgomery 5 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 20815 United States 3204 Pauline Drive 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Examiner Black, White, etc. . or ! þ 1 Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: Caucasian "natural", Completed 3 Widowed 4 X Divorced Year or Dates Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) the 5+ Software Developer Software Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o ည Royce Dixon Jordan Jerrie Maxine Hood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s f Health item 27 3204 Pauline Drive, Chevy Chase, Maryland 20815 Barbara Peck, Companion 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any injury or o of ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 3/28/2012 Alexandria, Virginia Signature of Funeral Service Licensee 22. Name and Address of Facility Simple Tribute MO1102 KOWE 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory are shock, or heart failure. List only one cause on each line. Approximate terval Between Onset and Death Immediate Cause (Final Physician/ eros disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, ir any, reading to immediate cause. Enter Underlying Due to (or as a concequence on) Exami Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buris Physician/Medical death certificate be Box 68760 122/12 as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death detached Unknown g 🗌 Unknown P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autons has page Yes 1 🗌 Yes Division of Vital rector, To the Hospital or Attending Physician: 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital Other: ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 5 Pending Natural within 24 hours after ueau...

To the Funeral Director: A M Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8600 010 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	_	For State		State	of Marylai	'			alth and N	∕lental Hy	giene	20	12	10117		
		Registrar 1. Decedent's Name	a First Middle I	act)		Се	rtificate (of De	ath	2. Date of De	Reg. No	U	1 6-	10111		
Physician		Diane E1			C					Month 3/14/2	Day	y Y	ear	3. Time of Death 9:45 P M		
Medic Examine		4a. Facility Name (if					4b. City, Tov	wn, or Lo	cation of Death	12/14/2		County of	Death	7.45 1		
		11337 Ly	dia St				Bishop	vill	e		W	lorces	ter			
Funeral		5. Social Security No.	umber 6	. Sex 1 ☐ M 2 🛣 F	7. Age (In yrs. 58	last birthday) Yrs.	If Under 1	Year If	Under 24 Hrs. Hours Min.	8. Date of Bir 1 / 1 / 1 9 5		g	Birthpl	ace (State or Foreign y)		
Director	ł	Usual Residence of			76	110.				μ///195)4		IA			
land show	ţċ	10a. State	10b. County			ity, Town or Lo							10	d. Inside City Limits		
Many 28a-	jred	MD	Worces	ter	Б.	ishopv:								1 🗆 Yes 2 🎦 No		
ith the	ra	10e. Street and Nun					10f. Zip Co				10g. Cit	izen of Wha	at Count	ry?		
ems ar mus	Funeral Director	11. Marital Status	yula St.	12. Was Dec	edent Ever in U	.S. 13.	Was Decedent	t of Hispa	anic Origin? (Spe			14. Race - American Indian,				
fter de	<u>اچ</u>	1 Never Marr		d Armed Formal Arm	2X No		If Yes, specify 1 ☐ Yes 2	_	Mexican, Puerto	Rican, etc.)		Black, White, etc.				
ours a	Completed	3 Widowed	4 Divorced	Year or D		160 Door	edent's Usual C					эреспу.				
n 72 h	ם	(Spe	ecify only highest	grade completed	1) 1-4 or 5+)	(Give		lone durir	ng most of work	ing	16b. K	ind of Busir	ness ind	ustry		
withir giene er th t, the		Elementary/Seco	oriday (0-12)	1	1-4 01 5+)	cler	k				Wor.	Co.	Dis	trict Court		
e filed ntal H) ed oth even	To Be	17. Father's Name (18	3. Mother's Nam		Maiden	Sumame)				
d Mer mark matic	⁻ ∤	Richard 19a. Informant's Na				10h Mail	in a Andreas (C)	*****	Anne Ha		or City or	Town Stat	o Zio Ci	odo)		
12 sho alth an 27 Is r trau				(husband)				Bishop				e, 21 <i>p</i> 00	ide)		
of Hee	ı	20a. Method of Disp		□ Removal from		Place of Disp	osition (Name o	of er place)		Date	20c. Lo	ocation - Ci	ty or Tov	vn, State		
Page ment tant: I			5 Other (Spe		Otate	kemie	Cemeter	У		3/2012		v Hill				
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentall Hygiene. Important: If tiem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Merical Examiner must be notified at once.		21. Signatur of Fu	n Al Service Lic	3ucha (7	2			of Facility The				L Ho	me		
	\neg	23a. Part 1. Enter t	the disease, or co	omplications that y one cause on e	caused the dea	th. Do not en	ter the mode o	f dying, s	such as cardiac	or respiratory ar	rest,			Approximate Interval Between		
hysician/		Immediate Cause ((Final		3 reast	Can	cer							Onset and Death		
Medical Examiner		resulting in death)	6	Due to	(or as a consec	quence of):										
	-	Sequentially list co		b. — Due to	(or as a consec	uence of):							_			
ansit	Examiner	cause. Enter Under Cause (Disease or	rlying iinjury		,	,										
ate be executed physician and the burial-transit	<u> </u>	that initiated events resulting in death) l		Due to	(or as a consec	quence of):										
ate be ohysic the bu	edical		•	d									_			
ding p	Ĭ,	IF FEMALE: 23b. Was decedent	pregnant	23c. If <u>ye</u> s, ou	tcome of pregn	ancy						23d. Date of	of delive	rv		
e atter	Physician/Me	in the past 12 in Yes 2	months?	4 L Pre	gnant at time of		☐ Ectopic pred ☐ Other (speci	gnancy ify)				Month		Day Year		
t the c by the		g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I.														
es tha signec	β	4 4	atitis	Continuenting to	death but not re	saiting in the	underlying cau	se giveri	III CALL	1 🗆				e cause of death?		
requir been should	Completed									24a. Was		24b. We	re autop	sy findings available		
he law te has age 2	d l										psy ormed? 2000 No	dea		npletion of cause of		
ian: T	Be C	25. Was case referre	ed to medical				2	26. Place	of Death (Chec		200,111					
hysic this ce al dire	၉	1 ☐ Yes 2 X	No		Inpatient 2	T			4 Nursing Ho				Specify)			
ding F th. After funer	cate	27. Manner of Death Natural 2 Accident	5 Pending		ot Injury oth, Day, Year)	28b. Time of injury	M 28c.	Injury at work?	s 2 🗆 No	28d. Describe I	how injur	y occurred				
Atten er dea' ector: by the	Certificate	3 Suicide 4 Homicide	6 Could no	ot be 28e. Plac	e of Injury - At h					28f. Location (r Rural I	Route Number,		
ital or urs after ral Dir lled in					ling, etc. (Speci					City or Tov						
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit completed filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Medical	(Check 2	Medical Exa	Physician: To the aminer: On the ba lurse Practioner	isis of examinati	on and/or inve	stigation, in my	opinion, o	death occurred a	t the time, date a	and place	, and due to	the cau	se(s) and manner stated.		
with vith con the control of the con		29b. Signature and	title of certifier	MI)			cense nu	_ i		29d. Da	te signed (A	Nonth, D	lay, Year) , 2012		
		90 No.	119	7 . +	on of death W	m 02c\ /T	Drint\	103	1204		1			, 2012		
A6			met L	Ju 10	DE.Ca	XYD\\	St. S	alig	sbury	MD	218	801				
Stat Registra		31. Date filed (Mont	MAR 16	2012	Registrar's Sign	d.	back	,								

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Keach 11:45 BM March Charles 22,2012 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Sanctuary At Holy Cross Burtonsville Montgomery Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday, **Funeral** Hours (Month, Day, Year) 1 X M 2 □ F Director 347-18-9030 86 Dec. 2, 1925 Illinois Fshow and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f shov aumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. Count 10c. City, Town or Location Director 1 ☐ Yes 2 🕅 No Maryland | Montgomery Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20707 United States 15900 Aitcheson Lane within 72 hours after death 12. Was Decedent Ever in U.S.
Amed Forces? Korean
11 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 If Yes, Give Conflict Year or Dates. 1 Yes 2X No Specify: Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Clinical Psychologist Private Practice Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be 1 Department of Health and Menta. Important: If item 27 is marked. any injury or other traumatic eve once. ည Lucille Campbell Charles J. Keach 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10406 Huntley Avenue, Silver Spring, Maryland 20902 Sharon E. Keach/Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State Marchate 24, Metropolitan Crematory 2012 4 Donation 5 Other (Specify) Alexandria, Virginia 21. Signature of Funeral Service Licen ee Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Assiration Physician/ pneumonia disease or condition Medical resulting in death) Due to (or s a consequence of) **Examiner** ysphagia Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Exami and Due to (or as a consequence of): resulting in death) Last ng physician a as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 this certificate has been signed by the attending I ral director, page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23h. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Day Year 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Syndrome Myelodysplastic 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performe 1 ☐ Yes 2 ☐ No 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certifice completely filled in by the funeral director, I Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 🗹 No Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Medical Certificate: 28d. Describe how injury occurred iniury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pendina 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one Tot 29b. Signatur 29c. License number 00053337 March 232012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Don'thy Secy mb 2835 Smith Ste zoz Anenue

State

Registrar

31. Date filed (Month, Day, Year)

26

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ľď 2012 6:00 Joy Marjorie Krissoff Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Hours Months **Director** 065-24-2162 80 1 M 2 X F 5-7-1931 PA Usual Residence of Decede ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 ☐ No MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 915 Caddington Avenue 20901 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black White etc. 1 ☐ Never Married 2X Married Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygien is marked other th Book Keeper Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည David Fishman Kathryn Fishman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health Robert Krissoff - Husband 915 Caddington Avenue, Silver Spring Maryland 20901 Baltimore, If item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State injury or 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Judean Mem. Gardens 3-12-2012 Olney, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Edward Sagel Danzansky-Goldberg #M00910 1170 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Pneumonia Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): and and death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 X No Month Day Year signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ End Stage Renal Disease - NOT DIALYSED Records, 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a, Was an autopsy performed death? 1 ☐ Yes 2 ☐ No Yes of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 1 Yes 2 X No 1 X Inpatient 2 ER/Outpatient 3 DOA ဂ 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 1 X Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred eral Director; After filled in by the funer To the Hospital or Attending 5 Pending Division Accident 1 Yes 2 No Investigation
6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours a Funeral L 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10 D0069288 3-10-2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) - 1500 Glen Forest Road, Silver Spring, Maryland 20910 Yodit Negusse, MD

DHMH 17 Rev 06-2011

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 3 Physician/ 2012 P^{M} 8:10 Zoya Klempner Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Hebrew Home Of Greater Washington Montgomery Rockville Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 6-6-192 Country)
Russia Months Days Hours Min. 215-94-8753 88 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director MD 1 X Yes 2 No Montgomery Rockville 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 11801 Rockville Pike #1503 20852 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces?
1 ☐ Yes 2 XNo If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates White 3 Divorced 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Home Maker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Issac Uerukhimoyich Netta Bylek 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lev Klempner - Son 715 Key Royale Dr., Holmes Beach, Florida 34217 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 3-18-12 4 Donation 5 Other (Specify) Olney, Maryland Judean Mem. Gardens 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Edward Sagel Funeral Direction Edward Sagel 2 #M00910 1091 Rockville Pike, Rockville, Maryland 20852 23a, Part 1, Enter the disease, or complications that caused the death, Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Pnysician Heart ongestive disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed s been signed by the attending physician and should be detached for use as the burial-tens that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) g | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has tuneral director, page 2 s autopsy performed? 1 ☐ Yes 2 🗙 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 🛣 No ၉ 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a, Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number mina 3-16-2012 farle D0064871 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6121 Montrose Rockville 20852 MD Fazli 31. Date filed (Month, Day, Year) State MAR 27 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene

		-	For State of Maryland / Dep	ertificate of D			g. No. On t	2 10121
	Physicia		1. Decedent's Name (First, Middle, Last) Athena C. Kalivas			2. Date of Death	20,2012	3. Time of Death 1:41a M
-	Medic Examin		4a. Facility Name (if not institution, give street and number) Shady Grove Adventist	4b. City, Town, or l	Location of Death		4c. County of Deat	omery
	Funeral Director		5. Social Security Number 216-40-6928 6. Sex 1 \square M 2 \boxtimes F 7. Age (In yrs. last birthday Yrs.) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth 1 1 1 1 4 1 1	9. Bir	thplace (State or Foreign untry) CEECE
	aryland a-f show fied at	ector	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or I MD Montgomery Potc	Location DMaC				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	vith the Ma 23a or 28 st be noti	Funeral Director	10e. Street and Number 12301 Overpond Way	10f. Zip Code 20854	1	10	g, Citizen of What Co USA	
960	permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 ▼ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ▼ No If Yes, Give Year or Dates.	3. Was Decedent of His If Yes, specify Cuban		cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
Maryland 21215-0036	ithin 72 hou ene. • than "natu he Medical	Completed	(Specify only highest grade completed) (Giv	eedent's Usual Occupa re kind of work done du DO NOT use retired) Homemak e	urina most of worki	ng 1	6b. Kind of Business Own Ho	
land 2	be filed wi lental Hygis rked other ic event, t	To Be (17. Father's Name (First, Middle, Last) Spiros Covotsos		18. Mother's Name Katina	e (First, Middle, Ma Panas	iden Surname) Viotakis	
	d 2 should alth and M 127 is mai r traumat			illing Address (Street ar				
Baltimore,	Page 1 and nent of Her int: If item iny or othe		1 Rurial 2 Cremation 3 Removal from State cemetery, cr	position (Name of rematory or other place ore Nat •]	e) [Oc. Location - City or	
Balti	permit. Departn Importa any inju			PHTLTPdD: 9241 Colu				CE,P.A. ng,Md20910
	Ph _y sician/		23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line. Immediate Cause (Final hypotensive disease or condition		g, such as cardiac c	r respiratory arrest		Approximate Interval Between Onset and Death Minute S
Sep.	Medical Examiner		resulting in death) Due t (fr as a consequence of):					day 5
	uted d	aminer	Sequentially list conditions if any, leading to immodiate cause. Either Underlying Cause (Disease or linjury that initiated events	difficil	e colit		drys	
092	te be exec	edical Examiner	resulting in death) Last Due to (or as a consequence of): d.					/
Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial transit.	Physician/Me		Ectopic pregnancy	у		23d. Date of de Month	slivery Day Year
s, P.O.	ires that the dea signed by the a Id be detached f	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause give	en in Part I.			o the cause of death?
Division of Vital Records,	ne law require e has been si age 2 should l	Completed				24a. Was an autopsy perform	prior to death?	utopsy findings available completion of cause of
ital R	ician: The certificat ector, pa	Be	25. Was case referred to medical examiner? Hospital:	Other	ace of Death (Check		- 1	
n of V	ding Phys h. After this funeral dir	sate: To	1 Yes 2 Ano 1 Inpatient 2 FER/Outpat 27. Manner of Death 1 Another Structural 5 Pending (Month, Day, Year) 1 Another Structural 5 Pending (Month, Day, Year)	of 28c. Injury work?	4 □ Nursing Ho	me 5 Residen 28d. Describe how	ce 6 Other (Spec	oify)
Divisio	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director. After this certificate has completed filled in by the funeral director, page 2 or	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, to building, etc. (Specify)	11 - 2	103 2 2 1 10	28f. Location (Stre City or Town,	et and Number or Ru State)	ural Route Number,
	n 24 hours n 24 hours le Funera	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deat of the death of t	estigation, in my opinior	n, death occurred a	the time, date and	place, and due to the	cause(s) and manner stated.
	TO Within Comp		29b. Signature and title of certifier chen MD	29c. License	number Z 607	29	d. Date signed (Mont March 20	th, Day, Year)
			30. Name and address of person who completed cause of death (Item 23a) (Type Dr. Peter Chen, MD 9901 Medical Completed (Month, Day, Year) 31. Date filed (Month, Day, Year)	Print) 1 Conter D	Iriut, Roc	lovilla, m	nnylmd	20850
	Sta Registra		31. Date filed (Month, Day, Year) 22. Registrar's Signature	Made				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 A Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Michael Lilley 6:50 AM Medical County of Death Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Anne Avun Ghen MME 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Social Security Number If Under 24 Hrs 241-94-2063 Director 1**℃** M 2 🗆 F 56 1955 June 6 N. Carolina Usual Residence of Decedent Department of Health and Mental Hygiene. Important: If items 23a or 28a-f show Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10h County 10c. City, Town or Location 10d. Inside City Limits Director Marvland Anne Arundel Glen Burnie 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 363 Mae Road 21061 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian. 1 Never Married 2 X Married 1 Yes Completed by Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Anne Arundel Co. Elementary/Secondary (0-12) College (1-4 or 5+) 12th Public School 6vrs Educator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Welton Lee Lilley Sr Evelyn Kee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vivian S. Lilley(Wife) 363 Mae Road Glen Burnie, Md. 21061 20a. Method of Disposition 20A Slow mypostion wane Neck 20c. Location - City or Town, State Date Page 1 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) U.M. Church 3-17-12 Severna Park, Md. 21. Signature of Funeral Service Licensee Williams Reesen BellitSons Mortuary, P.A. 1922 Forest Dr. Annapolis, Md. 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ca Immediate Cause (Final Onset and Death Physician. disease or condition resulting in death) Medical Due to (or as a con equence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examir Cause (Disease or injury that initiated events resulting in death) Last numorio Due to (or as a consequence of) attending physiciar Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 W No
9 ☐ Unknown Pregnant at time of death
Unknown Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📈 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed? Yes 2 N 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 X Inpatient 2 - ER/Outpatient 3 - DOA eral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 Pending ours after death.

lera Director: Ai

filled in by the fu 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours Medical 29a. Certifier 🕻 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated and title of certifie 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) 327 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 301 ARI

Registrar

gistrar's Signature

MAR 1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ^{Day} 2012 Kathleen Marie Lilik March 11. 11:30 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Casey House-Montgomery Hospice Rockville . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Youly 12, 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 59 138-48-7323 Director 1 🗆 M 2 🏝 F Indiana 195228a-f shov with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at rector Maryland| Montgomery Germantown 1 ☐ Yes 2 🛂 No ۵ 10e. Street and Number ö 10f. Zip Code 10a, Citizen of What Country? ms 23a or must be Funeral 17530 Charity Lane 20874 United States filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, r than "natural", or iter the Medical Examiner Armed Forces?

1 Yes 2 No Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Completed 3 Widowed 4 Divorced Specify: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. URS Federal Services Account Manager Elementary/Secondary (0-12) College (1-4 or 5+) Government Contractor event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental F 27 is marked o traumatic eve မ Geraldine Woods Joseph R. Ellis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 start of Health a : If item 27 is Dennis A. Lilik (Spouse) 17530 Charity Lane, Germantown, MD 20874 altimore, other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Marchate 17. 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State ò Department Important: I any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Hickory Grove Cemetery 2012 Waverly, Pennsylvania Signature of Funeral Service 22. Name and Address of Facility DeVol Funeral Home, 1 RACULT (M001117)10 East Deer Park Drive, Gaithersburg, MD 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Lung Cancer with Metastases Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of, certificate be executed and Due to (or as a consequence of): resulting in death) Last ding physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ signed by the att Pregnant at time of death g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? certificate 1 ☐ Yes 2 🛛 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Yes 2 X No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) within 24 hours after death.

To the Funeral Director: After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be filled in by Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined To the Hospital Medical ☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and tit 29c. License number 29d, Date signed (Month, Day, Year) March 12, 2012 D37142 30. Name and address of person who completed cause death (Item 23a) (Type, Print) Geoffrey Coleman, M.D., 6001 Muncaster Mill Road, Derwood, MD 20855 31. Date filed (Month, Day, Year) State Registrar

			Plea									All Copi		_	ible.		
		For State		S	tate of t	Marylar					and N	/lental H	ygien	e 21	11:	2 10	1121
		Registrar 1. Decedent's Name	e (First, Middle	, Last)				ertifica	ite of L	Jeath		2. Date of I	Reg. N	lo.	J 1 6	3. Time o	f Dooth
Physicia Medic		Marjorie	e G.	Lawre	ence									^{Day} 201	2 ^{Year}		0 P M
Examin		4a. Facility Name (if	not institution	, give street	and number)				Location o	f Death		4	c. County	of Death		
Funoral		9221 DAVI 5. Social Security Nu		6. Sex		Age (In yrs.	last hirthda		Llege der 1 Year	Park If Under 2	24 Hrs.	8. Date of E		rinc		orges	or Familian
Funeral Director		220 56 42		1 🗆 M		88		Month		Hours	Min.	(Month,	Day, Year)		Cou	hplace (State o untry)	
od Jow at	'n	Usual Residence o	f Decedent 10b. County			10c Ci	ty, Town or	Location			1	April	28,1	923	wasn	ington	
farylar 8a-f sl tiffied	ecto	Maryland	Prin	ice Ge	orges		-	e Parl	ĸ								2 No
a or 2	II Dii	10e. Street and Num	nber					10f. 2	Zip Code				10g. 0	Citizen of \	What Co	untry?	
ith witl ms 23 must	Funeral Director	9221 Davi	dson S				o I.		740		. 0.40		US				
er dea or ite miner	by Fu	11. Marital Status1 Never Marrie	ed 2 🗷 Man	Α	Vas Deceden Irmed Forces	?	.5.	If Yes, sp	ecify Cuba	ın, Mexican,	n? (Spe , Puerto	ecify Yes or N Rican, etc.)	0-		k, White	-	
urs aff tural", al Exa	ted	3 🗌 Widowed 4		Y	Yes, Give ear or Dates			1 🗌 Yes	2X No	Specify:				Specify:	Wh	ite	
72 ho n "nai	Completed		15. Deceder cify only highe	st grade co	mpleted)		(G	cedent's Usive kind of w	ork done d		of work	ing	16b.	Kind of B	usiness/l	Industry	
within giene. ier tha		Elementary/Seco	ndary (0-12)	C	ollege (1-4 o	r 5+)		ce Mai					Re1	igio	us O	rganiz	ation
e filed tal Hy ed oth event	To Be	17. Father's Name (F			mp							e (First, Midd			e)		
ould b nd Mer mark matic	_	19a. Informant's Na					10b M	ailina Addra	ss /Stroot			al Route Num			tata Zin	Codol	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		Joseph Pa				r./Sp											0
t of He If iten or oth		20a. Method of Disp	Cremation	3 🗆 Remo	oval from Sta	to (cemetery, c	sposition (N crematory or	other plac	:e)		Date			-	Town, State	
it. Pag urtmen ortant: njury		4 Donation	5 X Other (S	pecify) En	tombme	nt Ga	te of					2/2012	Sil	ver S	Spri	ng, Mar	yland
Departi Impo any ir		21. Signature of Fun	eral Service L	John John	(آفم	.024	1	Hines	-Rina	ss of Facility 1d1 Fr	unei ire	al Hou	e, I	nc.	rino	MD 20	904
		23a. Part 1. Enter the shock, or heart	ne disease, or t failure. List o	complication	ons that caus	ed the deat	th. Do not	enter the mo	ode of dyin	g, such as c	cardiac o	or respiratory	arrest,	.r_ op		Approxima Interval Bet	te
Physician/		Immediate Cause (F disease or condition	Final		falign:		hymom	a								Onset and	
Medical Examiner		resulting in death)		r	Due to (or a	s a conseq	uence of):										
*	iner	Sequentially list con	mediate	b. —	Due to (or a	s a conseq	uence of):										
executed any and mine set	Examiner	cause. Enter Underl Cause (Disease or in that initiated events	njury	c													
@ E		resulting in death) L	.ast		Due to (or a	s a conseq	uence of):										
icate be g physici as the bu	Physician/Medical			d													
eath certifica attending p	an/N	IF FEMALE: 23b. Was decedent p	pregnant		yes, outcom			3 🗆 Ectopi	c pregnanc	EV				23d. Da	te of deli	ivery	
e deat the at thed fo	ysic	in the past 12 m 1 ☐ Yes 2 █ 9 ☐ Unknown	No		☐ Pregnan		death	5 Other	(specify)				-	Mo	nth	Day	Year
requires that the de been signed by the s should be detached	by Ph	Part II. Other signifi	cant conditio	ons contribu	iting to death	but not res	sulting in th	ie underlyin	g cause giv	en in Part I.		23e. Dio	tobacco	use conti	ibute to	the cause of c	leath?
quires en sign buld be	ted b											1 [Yes 2	2 X No	3 🗆 Pr	obably 4 🗌	Unknown
law red nas be e 2 sho	Completed												topsy		prior to c	opsy findings completion of c	
sician: The law certificate has t lirector, page 2 s		OE IMan cone referre	d to madical									1 🗆 Ye	rformed? s 2 X I		death? 1 🗌 Yes	2 🗌 No	
/siciar s certif	To Be	25. Was case referre examiner? 1 Yes 2		Hospit	al:	ationt 2	EB/Outpa	tient 3 🗆	Othe	ace of Deatler:		only one)	ai dan a a	e 🗆 Oah	· /C:	×.1	
ng Phy ter thi		27. Manner of Death	5 Pendin		Ba. Date of ir (Month, L	njury	28b. Time	of	28c. Injury work	/ at		28d. Describ				(y)	
ttendil death. tor: Ai / the fu	Certificate:	2 Accident 3 Suicide	Investig	gation not be				М	1 🗆	Yes 2 🗌	No						
ial or Attending Physics is after death. In Director: After this ce ed in by the funeral director.		4 Homicide	determ	ined 28	Be. Place of I building,	njury - At ho etc. (Specif)		street, facto	ory, office				(Street a bwn, Stat		er or Run	al Route Numi	ber,
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the but the funeral director.	Medical	29a. Certifier 1	Certifying	Physician:	To the best	of my know	/ledge, dea	th occurred	at the time	e, date and	place, a	nd due to the	cause(s)	and mann	er as sta	ated.	nnor otata I
the Fithin 24 the Fithin 34 th	Me	only one) 3 29b. Signature and t	□ Certifying	Nurse Pra	ctitioner: To	th best of	my knowled	ige, death o	courred at t	he time, date	e and pla	ace, and due t	o the caus	se(s) and m	nanner as		amer stated
¥ ₹ ₽ \$		Signature and t	The or cerunal	1100		1	1		26386					ch 9,		, <i>Day</i> , Yea <i>r)</i> L 2	
		30. Name and addre	ss of person v	who comple	ted cause of	death (ten	n 23a) (Typ				rd.	MD	1101				
		2021 K.	Street		Suite	310,	Wash	ingto	n, DC	-	_						
Stat Registra		31. Date filed (Month	R 14 2	2012	37. Regis	trar's Signa	ire d	ales	,								
					4-4-1												

	For State Registra AMFND#17+18pe	State of Ma		/ Depa	artment of I tificate of L	lealth	and N	-		20	112	Ballyana	012	
ian/ ical	Decedent's Name (First, Middle, Le Ramon Lugo 4a. Facility Name (if not institution, given the properties)				4b. City, Town, or	v Legation	of Dooth	2. Date of De Month March	7, D	2012	Year		of Death	
iner	7202 Garland Ave				Takoma				- 1	County Mont	of Death	У		
		22	e (In yrs. last i		If Under 1 Year Months Days	If Unde Hours	er 24 Hrs. Min.	8. Date of Bir (Month, Da			9. Birthp Count		e or Foreig	
	Usual Residence of Decedent	1 X M 2 □ F	64	Yrs.				July 2	5, 1	947	Puer	to R	ico	
Director	10a. State 10b. County Maryland Montgom	orv	10c. City, To	own or Loo ma Pa							10		City Limits	
	10e. Street and Number	Cly	Tako	ша г	10f. Zip Code				10g. Ci	itizen of W	Vhat Count		es 2 🗆 N	
Funeral	7202 Garland Ave	nue			20912				Uni	ted	State	s		
by Fu	11. Marital Status1 ☐ Never Married 2 ☐ Married	12. Was Decedent E Armed Forces? 1 X Yes 2		13.\	Nas Decedent of H f Yes, specify Cuba	ispanic O In, Mexica	rigin? (Spe an, Puerto	ecify Yes or No- Rican, etc.)			e - America k, White, e			
ted b	3 Widowed 4 X Divorced		1966-7	1	Yes 2 No	Specify	Pue	rto Ric	an	Specify:	Cauc	Caucasian		
Completed	15. Decedent's (Specify only highest g		1	(Give	dent's Usual Occup kind of work done o O NOT use retired)	during mo	st of work	ing	16b. K	Kind of Bu	siness/Ind	ustry		
	Elementary/Secondary (0-12)	College (1-4 or 5			ation Off				Juv	eni1	e Ser	vice	s	
To Be	17. Father's Name (First, Middle, Last, David Lu					ur	her's Nam nknown nown	e (First, Middle, Pagan	Maiden	Surname)			
	19a. Informant's Name/Relationship (ng Address (Street									
	Laura Lathrop, F 20a. Method of Disposition		20b. Place	e of Dispo	Garland sition (Name of			Lakoma Date			rylan City or Tov			
	1 ☐ Burial 2 🙀 Cremation 3 [4 ☐ Donation 5 ☐ Other (Spec		1	-	natory or other place oln Crema	1	3/1:	3/2012						
	21. Signatule of Funeral Service Licer	nsee MO110		22	. Name and Addres	ss of Faci	lity S :	imple T	ribu	te				
	23a. Part 1. Enter the disease, or cor	nplications that caused	the death. D		040 Rockv				-	e, M	aryla	nd 2		
	shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each line	e. •			9, 040			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			Interval E Onset ar	Between	
	resulting in death) Due to (or as a consequence of):													
er	Sequentially list conditions, if any, leading to immediate Diabetes mellitus Due to (or as a consequence of):													
Examiner	cause. Enter Underlying Cause (Disease or injury	Choles		oe 01 <i>j</i> .										
al Ex	that initiated events resulting in death) Last	Due to (or as a	a consequenc											
edic		d												
Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Fetal de	eath 3 [th 3 Ectopic pregnancy 23d. Date of comparison of the comparison							ry Day	Year	
	Part II. Other significant conditions	contributing to death b	ut not resultir	ng in the u	nderlying cause giv	ven in Par	t I.				ibute to the			
Completed by		W-2011 A.								1			Unknow	
dwo					<u>. </u>				psy ormed?	p	rior to con leath?	npletion o	gs available of cause of	
BeC	25. Was case referred to medical examiner?				26. PI	ace of De	ath (Chec	1 🗌 Yes k only one)	2 X N	10 1	☐ Yes	2 🗀 No		
2	1 Yes 2 X No	Hospital: 1 Inpation	ent 2 ER	Outpatier		4 L N		ome 5 🗶 Resi						
cate	1 Natural 5 Pending 2 Accident Investigation	(Month, Day		injury	work			28d. Describe I	now injur	ry occurre	ed			
Certificate:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined	be 280 Place of Init	ury - At home c. (Specify)	, farm, stre	eet, factory, office			28f. Location (City or To			r or Rural i	Route Nu	mber,	
Medical	(Check 2 Medical Exam	ysician: To the best of niner: On the basis of e	xamination an	d/or invest	tigation, in my opinio	on, death o	occurred a	t the time, date	and place	e, and due	to the cau	se(s) and	manner sta	
Σ	29b. Signature and title of certifier	rse Practitioner: To the	e best of my k	inowleage,	29c. License		late and pla	ace, and due to			(Month, D			
1	> Lucedness	w MD			000	1622	2/		3/	19/12				
	30. Name and address of person who				Print)					7				
ite	Solomon Mark Swi 31. Date filed (Month, Day, Year)	erdsiol, 8:	31 Uni	versi	ty Blvd.	Ε.,	Suit	te 26.	Silv	er S	pring	, MD	20903	
rar	MAD 15 201	2 Pegistra	. 4.	400										

Registrar

MAR 20

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 601 PM _M Physician/ Ρ. March 8, **2**012 Year Yuriy Leonov Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Suburban Hospital Bethesda If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days 04/12/1939 1 ₹M 2 □ F 218-31-7629 Director 72 Yrs. Russia Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🛚 Yes 2 🗆 No Rockville MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20850 United States 717 Anderson Avenue Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, han "natural", or it 9 Medical Examine Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify White Specify: Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 72 i Department of Health and Mental Hygiene. Important; if item 27 is marked other tran "ns any injury or other traumatic event". (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Mechanic Automotive Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Sarah Apter Peter Leonov 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13544 Glen Mill Road Rockville MD 20850 Vladimir Gurevich - Son in law 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Parklawn Memorial Park 3/11/12 Rockville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Danzansky-Goldberg Memorial Chapels Inc 1170 Rockville Pike Rockville MD 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Ventricular Fibrillation disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Ischemic Coronary Artery Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Anoxic Encephalopathy that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Day Pregnant at time of death the g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Prosthetic Aortic Valve 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy this certificate 1 ☐ Yes 2 ☐ No Yes 2 🛣 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 🛣 No မ 1 🔀 Inpatient 2 🗆 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) injury 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 😾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) your U. Kleychak March 09, 2012 D41311 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

WAR 20

ecmoy,

Yuri A. Deychak MD 8600 Old Georgetown Road Bethesda MD 20817

Registrar's Signa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Edelmira Melo 3^M/m⁴ 3 / 20^M/₂2 Lora 0705 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Casey House Rockville 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours 2/28/1955 577-94-7555 **Director** 57 1 □ M 2**X** F Dominican Rep Usual Residence of Decedent show 10a. State 10c. City, Town or Location 10d. Inside City Limits must be notified at Director MD Montgomery Silver Spring 1 ☐ Yes 2 X No 28a-f ō 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 23a 1024 Quebec Terrace #T-2 20903 USA items Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Armed Forces2 1 ☐ Yes 2 ☐ No Black, White, etc 0. 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene.
Item 27 is marked other than "natural", or 1 Never Married 2 Married 1 X Yes 2 □ No Specifican Rep. Baltimore, Maryland 21215-0036 Specify: Black If Yes, Give Completed 3 - Widowed 4 Divorced Year or Dates traumatic event, the Medical Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education Montgomery County (Specify only highest grade completed) Cafeteria aid Elementary/Secondary (0-12) 12 College (1-4 or 5+) Public Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fis marked o ည Virgilio Melo Olga Lora 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vanessa Ramos/Daughter 1242 First Street Rockville, Md. 20850 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 3/19∳2012 Puerto Plata Page 1 1 X Burial 2 Cremation 3X Removal from State Municipal Cemetery Dominican Republic 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur PHIMIP AD RINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring,Md 20910 nter the 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Cervical cancer disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Due to (or as a consequence of): resulting in death) Last attending physiciar Physician/Medical certificate be Box 68760 the as IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 23d. Date of delivery for in the past 12 months? Pregnant at time of death 1 ☐ Yes 2 ☐ No 9 Unknown P.O. g Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 😾 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 K No certificate has To the Hospital or Attending Physician: The 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: မ 1 Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🕱 Other (Speciforspice After this pletely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred Natural 5 Pending injury 24 hours after death.

Funeral Director: A Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated X Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) R143201

Registrar

State

6001 Muncaster Mill Rd Rockville, Md

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Deborah Miller CRNP

MAR 16 2012

31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

			Please	State of N				nt of Health				•		
	•	For State Registrar		Otate of it	riai yiai			te of Death			Reg. No	001	2 [1120
Physicia Medic		1. Decedent's Name (Firs Mary M.		st) Luca:	S					2. Date of Dea Month March 2	ath	No 12 Year		of Death
Examin		4a. Facility Name (if not in Care Well						y, Town, or Locatio Rockville			40	. County of Deat		
Funeral Director		5. Social Security Number 578-07-1269	er 6. S			last birthday) Yrs.		er 1 Year If Und	er 24 Hrs. Min.	8. Date of Birt (Month, Day Nov. 9		g. Bir	thplace (State untry) ington	_
land show d at	tor	Usual Residence of Dece 10a. State 10b.	. County		10c. C	ty, Town or Loc	cation						10d. Inside	City Limits
e Mary r 28a-1 notifie	Jirec	MD 10e. Street and Number	Montg	omery		Silver								es 2🏿 No
s 23a o	Funeral Director	3205 South	Leisu	re World	Blvd.		101. 2	ip Code 20906			10g. Ci	tizen of What Co	untry?	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ρ	11. Marital Status 1 ☐ Never Married 2 3 ☐ Widowed 4 ☐ [12. Was Decedent Armed Forces 1 Yes 2 If Yes, Give Year or Dates.	?	If	f Yes, sp	edent of Hispanic Cecify Cuban, Mexic 2 No Speci	an, Puerto	ecify Yes or No- Rican, etc.)		14. Race - Ame Black, White Specify: Whi	e. etc.	
thin 72 hou ene. than "natu he Medical	Completed			ducation rade completed) College (1-4 or	5+)	(Give F	kind of w O NOT u	ual Occupation ork done during mose retired) Negotia		ing		Gind of Business	-	nt
illed wall Hygir I other vent, t	Be	17. Father's Name (First, I	Middle, Last)					18. Mo	ther's Nam	ne (First, Middle,	Maiden	Sumame)		
Menta	욘	Alfonz		Ciango				Mar	ia Gr	azia Di	Lor	enzo		22226
2 shouth and the and the and the traum		19a. Informant's Name/R Woodrow Lu					_	ss (Street and Num h Leisure			-			20906
1 and of Heal item		20a. Method of Disposition	on	•••		Place of Dispos	sition (Na	me of		Date DIVI		ocation - City or		MD
it. Page rtment rtant: II njury or		1 Burial 2 Cre 4 Donation 5 X	Other (Speci	mentombme:	.C		coln	Cemeter		rch 26 2012		ntwood,	MD	
permi Depar Impo any ir		21. Signature of Funeral S	Service Licen	-		Fr 50	Name a Canci O Ui	ind Address of Fac Ls J. Col niversity	lins Lins Blvc	Funeral	Ho	me Inc. er Sprin	ng, MD	20901
Discontinuo /		23a. Part 1. Enter the dis shock, or heart failu Immediate Cause (Final	sease, or com ire. List only	plications that causone cause on each li	ed the dea ne.	th. Do not ente	er the mo	de of dying, such a	as cardiac	or respiratory arr	est,	•	Approxim Interval Bo Onset and	etween
Physician/ Medical Examiner		disease or condition resulting in death)	•	a. Alzhein Due to (or a			e						4 yrs	
	Examiner	Sequentially list condition if any, leading to immedia cause. Enter Underlying	ate	b. Due to (or as	s a consec	uence of):								
be executed sician and burial registr														
physici the bu	edical		•	d										
To the Hospital or Attending Physician: The law requires that the death certificate b within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompleted filled in by the funeral director; page 2 should be detached for use as the total states.	Physician/Medi	IF FEMALE: 23b. Was decedent pregn in the past 12 month 1 ☐ Yes 2 ☒ No g ☐ Unknown		23c. If yes, outcom 1 Live Birth 4 Pregnant 9 Unknowr	2 Tet at time of	al death 3	Ectopio Other (23d. Date of de Month	ivery Day	Year
that th ned by e detac	by Ph	Part II. Other significant				-			ırt I.	23e. Did to	obacco i	use contribute to	the cause of	death?
equires een sign ould be	tedt	Sick Sinus		ome, Aort	ic I	suffic	ienc	у,		1 🗆 '	Yes 2	IX No 3 □ P	robably 4 🗆] Unknown
The law recate has be page 2 sh	Completed	Severe Ane	mia							24a. Was autop perfo 1 🗌 Yes	sy rmed?	death?	topsy findings completion of 2 No	
sician certifi irector	o Be	25. Was case referred to rexaminer? 1 Yes 2 No	medical	Hospital:		150/0 : "		26. Place of De	,			XAssist	ed Liv	ing
ding Phy h. After this funeral d	sate: To	27. Manner of Death	Pending	28a. Date of in (Month, D	jury	ER/Outpatien 28b. Time of injury	М	28c. Injury at work?		28d. Describe h		Other (Spec y occurred	ity)	
tal or Atten rs after deal al Director: ed in by the	al Certificate:	2 Accident 3 Suicide 6 4 Homicide	Investigatio Could not to	oe 290 Place of Ir						28f. Location (S City or Tow		d Number or Rui	ral Route Nun	nber;
ie Hospi n 24 hou ie Funer oleted fill	Medical	(Check 2 M	ledical Exam	rsician: To the best on tiner: On the basis of the Practioner: To the	examination	on and/or invest	igation, i	my opinion, death	occurred a	t the time, date a	nd place	e, and due to the	cause(s) and m	nanner stated.
withii		29b. Signature and title of		,			29	c. License number	r		29d. Da	te signed (Month	, Day, Year)	
4				vhaoi				D24543			Mar	ch 20,	2012	
		30. Name and address of James A. Ro						rld Blvd	. S1	lver Sp	ring	r. MD 2∩	906	
Stat Registra		31. Date filed (Month, Day		€32. Regist	rar's Signa	ature face	J.		, ,,	<u></u>			2.00	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ MA(SZ) Lester Metcalf Mentzer, Jr. MICH Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Washington Meritus Medical Center Hagerstown Social Security Number If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) If Under 9. Birthplace (State or Foreign **Funeral** Months Hours 219-14-7599 Usual Residence of Decedent Director 1 🔀 M 2 🗆 F Oct.15, 1924 Yrs Maryland 87 show 10b. County with the Maryland 10a. State 10c. City. Town or Location 10d. Inside City Limits notified at Director 28a-f 1 Yes 2 X No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 9 10g. Citizen of What Country? ms 23a or must be r Funeral 17017 Hillsdale Ct. 21740 USA items within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Examiner Armed Forces? Black, White, etc. 1943 ö þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates. 'natural", Specify Completed 3 Widowed 4 Divorced 1945 White the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Education Custodian of Health and Mental Hygie If item 27 is marked other I other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, မ Lester Metcalf Mentzer, Sr. Mary Katherine Long 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .. Page 1 and 2 sh tment of Health a tant: If item 27 it Edna Mentzer - Wife 17017 Hillsdale Ct. Hagerstown, MD 21740 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Department o Important: If any injury or ō 4 Donation 5 Other (Spec Mar.20,2012 Williamsport, Maryland Greenlawn Mem. Park Signature of Fineral S Osborne Arthérally Home, P.A. MD 21795 425 S. Conococheague St.Williamsport, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Preumonia Physician/ 2 days disease or condition) Medical resulting in death) Due to (or as a consequence of) Examiner menths Sequentially list conditions, if any, leading to immediate ner Due to (or as a consequence of) Exami eavs or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events onar and burial-tran Due to (or as a consequence of resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months? Day Month Year Pregnant at time of death 2 No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 After this certificate has autopsy performe 2 No 1 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 🗌 Yes 2 No Accident Suicide Investigation 6 Could not be Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 \square Homicide determined within 24 hours a

To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and ti 00056379 30. Name and address of person who co impleted cause of death (Item 23a) (Type, Print) 5530 Wisconsin Ave \$700 Chery Chase, m. 20815 Marshall MD 31. Date filed (Month, Day

Registrar DHMH 17 Rev 06-2011

State

gistrar's Signature

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

			Plea	ise Type or							egible.					
		For State		State o	f Maryla		artment of F		/lental Hy	giene	010	1010				
		Registrar	- /5" - 1 - 1 - 1 - 1 - 1 - 1	1		Cei	tificate of L	Death		Reg. No.	<u>U12</u>	10131				
Physicia	n/	1. Decedent's Nam	Myrtle Myrtle		entzer				2. Date of De Month March		20 ^{Year}	3. Time of Death 3:39 PM				
Medic Examin			f not institution	, give street and num	ber)			Location of Death	March	4c. Cou	nty of Death					
<u></u>		5. Social Security N		ck Memoria	7. Age (In yrs.		If Under 1 Year	rederick	8. Date of Bi		reder					
Funeral Director		213-24-6 Usual Residence of	5347	1 □ M 2 X F	86	Yrs.	Months Days	Hours Min.	Month, D	8, 192	5 Mar	place (State or Foreign orry) yland				
s after death with the Maryland 'al', or items 23a or 28a-f show Examiner must be notified at	to	10a. State	10b. County		10c. C	ity, Town or Lo	cation				1	10d. Inside City Limits				
Mary 28a-f otifie	irec	MD	Washi	ngton	Kno	oxville						1 🗌 Yes 2 🎾 No				
death with the Maryland ritems 23a or 28a-f sho ner must be notified at	Funeral Director	10e. Street and Nur					10f. Zip Code				of What Cour	ntry?				
ath wi	nuel	18824 S	Sandy H	ook Road	dent Ever in U	S 113 1	21758		ocify Voc or No		USA					
er de: or ite miner	by F	1 Never Marr	ried 2 Mar	ried Armed For	ces? 2 X No		Was Decedent of Hi f Yes, specify Cuba		Rican, etc.)	14. F	Race - Americ Black, White,					
ırs aft ural", I Exa	ted I	3 X Widowed	4 Divorced		9		I□Yes 2ⅨNo	Specify:		Spec	eify: Whi	te				
72 hou "nati	Completed		ecify only highe	nt's Education est grade completed)		I (Give	dent's Usual Occup kind of work done o	ation during most of work	ing	16b. Kind o	f Business In	ss Industry				
ithin iene.	Co	Elementary/Sec	onday (0-12)	College (1-	4 or 5+)	1	odian			111 5	Gover	nment				
filed within 72 hours after al Hygiene. d other than "natural", or vent, the Medical Exami	Be	17. Father's Name (First, Middle, L	.ast)		1 0000	Jaran	18. Mother's Nam	e (First, Middle			mich				
id be i Menta arked atic e	욘	John E.	Reyno	1ds				Margare	t M. Wa	lker						
12 should be filed within 72 hours alth and Mental Hygiene. 127 is marked other than "natura re traumatic event, the Medical E.		19a. Informant's Na	ame/Relationsh	nip (Type, Print)		19b. Mailir	ng Address (Street a	and Number or Run	al Route Numb	er, City or Towi	n, State, Zip (Code)				
and 2 Health em 2 ther t		Beth Can 20a, Method of Disp		Daughter	Look		. Box 102	1								
age 1 ant of ft: If it	П	1 💢 Burial 2	☐ Cremation	3 Removal from	State	cemetery, crer	sition (Name of natory or other place	:e)	Date		on - City or To					
permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other trai once.	1	4 Donation 21. Signature of Fu			58		Manor Cen	an of Facility	9/2012							
Der		22. Name and Address of Pacinity Eackles-Spencer & Nor Home - Harpers Ferry, WV 25425 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dyfig, such as cardiac or respiratory arrest,														
		23a. Part 1. Enter t shock, or hea	the disease, or	complications that conly one cause on eag	aused the dea	ath. Do not ente	er the mode of dy	g, such as cardiac	or respiratory a	rrest,		Approximate Interval Between				
Physician/		Immediate Cause (disease or condition		16	espi.	roty	Falls	4				Onset and Death				
Medical Examiner		resulting in death) a. Due to (or as a consequence of)														
	je	Sequentially list co	onditions,	b. Due to (c	y pop	guence of):		-								
uted d ansit	Examiner	cause. Enter Unde Cause (Disease or that initiated event	rlying iinjury	CE	PD	ena	ecerbe	Acon	_			3 days				
9 E 6	Ä	resulting in death)	Last	Due to (or as a consec	quence of):		<u> </u>				0				
cate be physici s the bu	dica	d														
ding page as	<u>×</u>	IF FEMALE: 23b. Was decedent		23c. If yes, outo	come of prean	ancv										
eath c atten d for u	iciar	in the past 12 in the	months?	1 Live E 4 Pregr	Birth 2 🗌 Fe	tal death 3	Ectopic pregnanc Other (specify)	:у		1	Date of delive Month	ery Day Year				
the d by the tached	Physician/Medica	9 🗌 Unknown		9 □ Unkn												
v requires that the death certific been signed by the attending is should be detached for use as	Ω.	Part II. Other signif	ficant conditio	ons contributing to de	eath but not re	esulting in the u	nderlying cause giv	en in Part I.				ne cause of death?				
equire	eted					<u> </u>						bably 4 🗌 Unknown				
e law i e has b ge 2 s	Completed								24a. Was			psy findings available mpletion of cause of				
in; Th tificate or, pa	Be Co	25. Was case refern	ed to medical				26 PI	ace of Death (Chec.	1 Tyes	2 N o	1 Yes	2 No				
nysicia iis cert direct	10 B	examiner?	No	Hospital:	npatient 2	BR/Outpatier	Othe			idence 6 🗆 C	ther (Specify	1				
ing Pt		27. Manner of Deat	h 5 🗌 Pendin	28a. Date of (Montal	of injury h, Day, Year)	28b. Time of injury	28c. Injury work	/ at	28d. Describe							
ttendi death stor: A / the fi	2 Accident Investigation M 1 Yes 2 No															
after Direct		4 Homicide	determ		of injury - At r ig, etc. (Speci		eet, factory, office		28f. Location (City or To		nber or Rural	Route Number,				
To the Hospital or Attending Physician; The law requires that the death certificate be within 24 hours after death. To the Funeral Director After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but	Medical	29a. Certifier 1	Certifying	Physician: To the be	est of my know	wledge, death o	occured at the time	, date and place, ar	d due to the ca	ause(s) and ma	nner as state	d.				
the He hin 24 the Fu	Med	only one) 3	Certifying	Nurse Practioner: T	s of examination of the best of r	on and/or invest ny knowledge, o	tigation, in my opinic death occurred at the	on, death occurred a e time, date and place	t the time, date se, and due to the	and place, and ne cause(s) and	due to the car manner as st	use(s) and manner stated. ated.				
P with		29b. Signature and	title of certifier	MI			29c. License	number	2	29d. Date sig	ned (Month, i i f	Day, Year)				
		20. Nome and additi	ss of person	who completed cause	o of dood! ///	d od-\ m	Do	0712	7(2	19-	1				
IW-3		30. Name and addr	ESS OF DEISON	Ar STIM	Smi	Lay (Type, F	100 W.	744 5	of Fr	edeni	ch d	10				
State		31. Date filed (Mont	MAN'T'S	2012 32.	gistrar's Sign	ature	ad.			-						
Registra	r		-141110	1	a character of	M. A.	The state of the s									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 13^{pay} 2012 Pansy Pearl Mangold McIntyre 18:20pm Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Meritus Medical Center Hagerstown 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F Months Days Hours Min. Keyser, 101 Yrs. Director <u>234-60-2828</u> Usual Residence of Decedent shov 10a. State 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f X☐ Yes 2 ☐ No Washington Williamsport 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ō 27 is marked other than "natural", or items 23a of traumatic event, the Medical Examiner must be Funeral 21795 USA 16505 Virginia Ave. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 Xino
If Yes, Give If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 x Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72 h and Mental Hyglene.
7 is marked other than " Washington Co. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Hospital <u>Registered Nurse</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Lena Maphis Mangold David Mangold 19a. Informant's Name/Relationship (Type, Print) (daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Starboard Tack, Greenwood, SC 29649 <u>Margaret Bowman</u> 20b. Place of Disposition (Name of cemetery, crematory or other place)

Restlawn Memorial 3/17/2012 20a. Method of Disposition 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cumberland, MD Gardens. Name and Address of Facility 21. Signature 917 Cemetery Road Rosedale Funeral Home WV Martinsburg, 254d4 Ba. Part 1 Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) UE CO EEK Medical Due to (or as a consequence of) Examiner WEEK Sequentially list conditions Examine It ary leading to immedia cause. Enter Underlying Cause (Disease or iinjury WEEK LOSTRIDIUM DIFIBILE attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant a 9 Unknown Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DESTRUCTIVE PULMODARY the Hospital or Attending Physician: The law requires 3 Probably 4 Unknown 2 🗌 No 24b. Were autopsy findings available prior to completion of cause of death? ARTERIOSCUEROTIC CARBIOVASCULAR 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No DEMENSTIM 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ပ္ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation within 24 hours after death

To the Funeral Director:
completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier a mo D18019 Z

State Registrar

3

HAGERSTOWN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Reg. No. 2 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death HARLES Month Physician/ MATHEWS 12 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Tate Hospice House Linthicum Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, 25 220-05-4774 Director 1 BM 2 D F 1906 Maryland 105 Yrs. Usual Residence of Decedent or 28a-f show e notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No Annapolis Maryland Anne Arundel 23a o. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Page 1 and 2 should be filed within 72 hours after death with 1 ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natural", or items 23a Funeral must 403 Oaklawn Ave 21401 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. than "natural", or iter he Medical Examiner Armed Forces?

1X Yes 2 No
If Yes, Give 1 0 Black, White, etc. , or ! Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: It Yes, Give Year or Dates. 1942-45 Specify: Black. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) the Ft. George Meade 8th Carpenter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Robert Mathews Elizabeth Nater 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Annapolis, Md. 21403 Doris Wright(Niece) 920 Wells Ave 20b. Place of Disposition (Name of cemetery, crematory or other place)
Maryland Veteran 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 f XBurial 2 \Box Cremation 3 \Box Removal from State 3-14-12 Crownsville, Md. 4 Donation 5 Other (Specify) Mana Jease Pallisons Mortuary, P.A. 21. Signature of Funeral Service Licensee 1922 Forest Dr. Annapolis, Md. 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. onset and Death Immediate Cause (Final Physiciani disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, teading to immediate Examiner Does to the en a reconstruction on if any, teading to framed cause. Enter Underlying Cause (Disease or injury Physician: The law requires that the death certificate be executed and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 the SB IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Pregnant at time of death signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an . Were autopsy findings available prior to completion of cause of page 2 autopsy certificate has perform death? 2 No 1 Tes Yes funeral director Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner?
1 \(\sum \) Yes 2 \(\bullet \) No Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending work? 1 Yes 2 No 1 Natural 5 Pending iniury 2 Accident
3 Suice ours after death.

Ieral Director; Aft
filled in by the fur Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a To the Funeral E Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check ertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Mont.

death (Item 23a) (Type Print)

OR

trar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 3 Physician/ 2012 a^{M} Cleat E. Mock 8:30 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HCR Manor Care Hyattsville Prince Georges If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 10/23/1929 242-38-6440 **Director** 1 🔀 M 2 🗆 F 82 Yrs Lexington, NC Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Prince Georges Temple Hills 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral with 4867 St. Barnabas Road Apt.T3 20748 United States within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. Armed Forces þ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black ii res, Give Year or Dates. 1947-52 3 ₩idowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Hygiene. 11 Clerk Federal Government and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Jess Mock Katie Steele 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Renita Mock-daughter 4867 St. Barnabas Rd. Temple Hills.MD 20748 item 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of I Important: If it any injury or o 1 X Burial 2 Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ouantico 3/26/2012 Triangle, VA 21. Signature of Funeral Service Licenses 22. Name and Address of Facility W. H. Bacon Funeral Home 3447 14th Street, NW Washington, DC 20010 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine TEN S that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 as the IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No for Day Month Year should be detached 9 Unknown Part IL Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ on tos Melletus To the Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy Consus Five 25. Was case ref d to medical perform Yes 2 No 1 Yes 2 No To Be (funeral director. 26. Place of Death (Check only one) examiner? 1 \(\text{Yes} 2 🗷 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) after death.

Director: After this 28a. Date of injury (Month, Day, Year) 27. Mann f Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Watural 5 Pending work? Accident
Suicide Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier completely 47867

State Registrar mas

31. Date filed (Month, Day, Year)

Rd # ZIG. Perckvillo

rson who completed cause of death (Item 23a) (Type, Print)

701

Rando

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

MAR 22 201

Box 68760

P.0.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 Year Physician/ 24, McGrath March Francis Xavier ам 9:56 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Suburban Hospital Bethesda Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Min. Hours Days 578-34-7925 Director 1 🗷 M 2 🗆 F 82 Feb. 13, 1930 Washington, DC Usual Residence of Decedent "natural", or items 23a or 28a-f sho 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location Director 1 Yes 2 X No MD Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5411 McGrath Boulevard 20852 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No 21215-0036 1 Yes 2 No Specify: Year or Dates. 1948-49 White 3 X Widowed 4 Divorced Completed event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) than, Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Accountant Financial Management Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked o ပ Joseph S. McGrath Agnes M. Riordan or other traumatic t. Page 1 and 2 should b tment of Health and Mer rtant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Ann Lira/Daughter 19601 Gassaway Lane, Germantown, MD 20874 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or otl Date cemetery, crematory or other place)
Gate of Heaven Cemetery 1 X Burial 2 Cremation 3 Removal from State March 28 Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service License 22 Name and Address of Facility Funeral Home Inc. 00 University Blvd. W., Silver Spring, MD 20901 Part 1. Exper the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph_sician/ obstructive disease or condition Medical resulting in death) Examiner meumou Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last executed been signed by the attending physician and Due to (or as a consequence of): Physician/Medical that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 4 Pregnant at time of death 9 Unknown Month Day Year 5 Other (specify) page 2 should be detached Yes 2 No 9 🔲 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires 24 hours after death.

Funeral Director: After this certificate has been sign 1 Yes 2 No 3 Probably 4 M Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 1 2 No 1 Yes Yes Division of Vital filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2 🖺 No ပု 1 Yes 1 A Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🖾 Natural 5 Pending injury 1 Yes 2 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) To the Hospital within 24 hours a To the Funeral D Medical 1 Acertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my know 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10+ MAD D71462 March 24, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8600 Old Georgetown Road, Bethesda, MD 20814 Dan M. Danila, MD 31. Date filed (Month, Day, Year, 32. Registrar's Signature State MAR 26 2012 Registrar

ranci

2

0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Norma Lou McAbee March 21^{Day} 20192r 4:20P. M Medical ta. Facility Name (if not institution, give street and number)
Renaissance Cardens at Riderwood Village 4b. City Town, or Location of Death Silver Spring Examiner Prince George's yrs. last birthday) 92 Yrs. Social Security Number 9. Birthplace (State or Foreign **Funeral** 7. Age (In 8. Date of Birth Months 379-14-1069 1 M 2 X F Hours JUUV20% 1919 Director Michigan Usual Residence of Decedent 28a-f shov at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified Silver Spring Maryland Prince George's 1 Yes 2 No 10e. Street and Numbe ms 23a or must be n 9 10f. Zip Code 10g. Citizen of What Country? 3160 Gracefield Road, #3119 20904 United States items death \ 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Examiner 14. Race - American Indian, Armed Forces or 1 Yes 2 No Black White etc. ģ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 🗆 Yes 2 🗖 No nan "natural", o White Specify 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) e 1 and 2 should be filed within 72 is to Health and Mental Hygiene.
If item 27 is marked other than "r pr other traumatic event, the Med College (1-4 or 5+) Elementary/Seconday (0-12) Professor Bowie State University Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ferris Arnold (unk) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 29G Ridge Road Greenbelt, Maryland 20770 Department of Health a Important: If item 27 is any injury or at Kyle Scott McAbee -son 20a. Method of Disposition
1 ☐ Burial 2 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 3/30/2012 Metropolitan Crematory Alexandria, Virginia 4 Donation 5 Other (Specify) . Signature of Funeral Service License Donaldovide Borgwardt Funeral Home. PA Wards VBa 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between
Onset and Death
years shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph. sician/ disease or condition resulting in death) Advanced Dementia Medical Due to (or as a consequence of) Examiner Arteriosclerotic Cerebral Vascular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical physicia the buri Division of Vital Records, P,O, Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) Month Year signed by the a 2 🔀 No 1 | Yes 2 | 9 | Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Chronic Renal Insufficiency 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page performed? Yes 2X No certificate 1 🗌 Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: မ 1 Tes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 XNursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work? 1 ☐ Yes 2 ☐ No. within 24 hours after death.

To the Funeral Director: As completed filled in by the fu Accident Suicide Investigation M 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined Medica 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eileen Gemmell, CRNP 3160 Gracefield Road Silver Spring, Maryland 20904

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

MAR 26 2012

2. Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 Year Grace Marie Marano P^{M} 9:21 March Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Wilson Health Care Center Gaithersburg Montgomery 8. Date of Birth Sept. 20,1913 6. Sex Age (In yrs. last birthday) Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 M 2 XF Hours Min. Italy 169-38-4179 Sept. Director 98 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he mattered as 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 20877 301 Russell Avenue #428 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 💢 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White If Yes, Give 3 X Widowed 4 □ Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Joseph Calcara Antonina Garofalo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pond Creek Lane, Cape May, NJ 08204 Joan M. Hodges (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Metropolitan Crematory 1 🗆 Burial 2 🔀 Cremation 3 🗀 Removal from State March 23 2012 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, VA 22. Name and Address of Facility DeVol Funeral Home, 10 Gaithersburg, . Signature of Funeral Service 10 East Deer Park Drive, rg, MD 20877 RACY M01117 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final -Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury 1 To the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of resulting in death) Last signed by the attending physician a be detached for use as the burial-Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 23d. Date of delivery should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Chronic atrial fibrillation 2 🗹 No 1 Yes 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 Renal disease stag 1 Yes 2 No 25. Was case referred to medical funeral director, 26. Place of De . h (Check only one) examiner? 2 🗷 No Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director. After the 27. Man r of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) work?
1 Yes 2 No Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) N. R. Wert Bis chlac March 23, 2012

State Registrar nes

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

14. ROBERT BIRSCHBACH,

31. Date filed (Month, Day, Year

201 RUSSEL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 2 For State Registrar Certificate of Death Decedent's Name (First Middle, Last) 2. Date of Death 3. Time of Death 2<u>012</u> Physician/ Month March 7 6:15 A M Jacob David Moses Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3503 Collier Road Beltsville Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Months Director 217-72-3279 1 🗶 M 2 🗆 F 75 July 24, 1936 India Usual Residence of Deced 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland must be notified at Director 1 Tyes 2 X No Beltsville MD Prince George's ō 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 20705 United States 3503 Collier Road items 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. 0, þ 1 Never Married 2 X Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify "natural", 3 Widowed 4 Divorced Specify. Completed Asian Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Printing Businessman Be 17. Father's Name (First, Middle, Last) ge 1 and 2 should be filed nt of Health and Mental H: If item 27 is marked of 18. Mother's Name (First, Middle, Maiden Surname) မ NTJ David Gnanam Abraham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beatrice Juanita Moses, spouse 3503 Collier Road, Beltsville, MD 20705 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Department o Important: If any injury or once. George Washington Cem 3/11/2012 Adelphi, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facili Hines-Rinaldi Funeral Home, Inc. medaudelarne 1232 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Acute Myocardial Infarction disease or condition resulting in death) Medical Due to (or as a consequence of **Examiner** Ischemic Cardiomyopathy vears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed years Coronary Artery Disease that initiated events Due to (or as a consequence of) resulting in death) Last physician Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: Physician/ 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No the 9 Unknown 9 Unknown signed by tall Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Diabetes Melitus, Hypertension, Hyperlipidemia 1 Yes 2 X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Jas autopsy performed? death? certificate 2 No ☐ Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 K Residence 6 ☐ Other (Specify) After this 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate 1 X Natural 5 Pending within 24 hours after deau.

To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifi PO no March 08, 2012. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6510 Kenilworth Avenue, #2600 Riverdale, MD 20737 M.D., Din, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 1 4 2012

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2012 March 14, 3:59 Рм Evelyn Ayers Murray Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Montgomery Rockville 10500 Rockville Pike #1702 If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Age (In yrs. last birthday) Days Hours Min 578-12-1266 Director 1 🗆 M 2 🔀 F 11/24/1920 Washington, DC 91 Usual Residence of Decedent 28a-f show "natural", or items 23a or 28a-f sho dical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 X Yes 2 No MD Rockville Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20852 United States 10500 Rockville Pike Apt. 1702 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify 3 Widowed 4 Divorced Specify: White Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker Be Department of Health and Mental H Important: If item 27 is marked oth any injury or Athers? 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Louis E. Park Sadie Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10500 Rockville Pike #1702 Rockville, MD 20852 Thomas Murray / Spouse Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) National Crematory 03/18/2012 Falls Church, VA Funeral Service License 22. Name and Address of Facility Joseph Gawler's Sons Inc. 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physiciani Onset and De Years Vascular Dementia disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Hypertension 5 Years Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that the death certificate be executed B 5 Years Hyperlipidemia that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 1 ☐ Yes 2 🔀 No 9 ☐ U*n*know*n* 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available 24a, Was an prior to completion of cause of death? within 24 hours after death.

To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 autopsy performe 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 🛂 No Hospital: Other: မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation M 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Medical 29a. Certifier Xertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 | Nedical Ex 3 | Certifying uner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Sig*n*ature and title d certifie 29c. License number 29d. Date signed (Month, Day, Year) D0053711 March 15, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pasquale Santini MD 5530 Wisconsin Ave. Suite 1400 Chevy Chase, MD 20815 31. Date filed (Month, Day, Year) State MAR 19 2012 Registrar

ther McGu	ire		e or Print in I ite of Marylan	d / Depa		f Health a			jible. 20	2 1014				
Physic	rian/	Registrar 1. Decedent's Name (First, Middle,	Last)		uncale 0	Dealli		Re 2. Date of Deat	g. No.	3. Time of Death				
dical Exan		HEATHER LYNN MO	CGIRE					Month March 13,	Day Year 2012	0949 hrs				
		4a. Facility Name (if not institution, 10526 Connecticut Ave		er)		4b. City, Town, Kensingto	or Location of Dea on	ath	4c. County of Deat Montgomery	h				
Funera		Social Security Number	5. Sex 7.	Age (In yrs. I	ast birthday)	If Under 1 Y			h(MM/DD/YYYY) 9. Bir					
Directo	r	577-96-6116 Usual Residence of Decedent	1 M 2 X F	36	Yrs		ays Hours M	lin. 03/18	/1975 Forei	puntry) MD				
Any		10a. State 10b. County		10c. City	Town or Local	tion				10d. Inside City Limits				
pu Auqu	i -	MD Montgon	nerv	Roc	kville					1 Yes 2 No				
taryla	Director	10e. Street and Number	-			10f. Zip Code	-	10	g. Citizen of What Cou	intry?				
ith the Maryland 23a or 28a-f show	늄	719 Grandin Ave	enue			20850			USA					
with	ie i	11. Marital Status	12. Was Decede			as Decedent of I		Specify Yes or No-	14. Race - Amer	ican Indian, Black,				
or ite	Funera	1 Never Married 2 Married	1 Yes	2 X No		Yes 2 X	an, Mexican, Puer	to Rican, etc.)	White, etc.					
s afte	<u>a</u>	3 Widowed 4 Divor		Specify: White										
hour "nate	P P	Elementary/Secondary (0-12)	College (1-4				pation (Give kind o ife. DO NOT use re		16b. Kind of Business/	Industry				
5-0036 lled within 7: Hygiene.	Completed	12th	35535 (1	o. o.,	Homema	aker			Home					
ed wil	၂ ဦ	17. Father's Name (First, Middle, L	ast)	ne (First, Middle, M										
be fill	BB	Michael Reed												
hould bend Mer is mar	ုင	19a. Informant's Name/Relationship	ber, City or Town, State											
MD and 2 sho calth and can 27 is		JoAnne Kenney/n 20a. Method of Disposition	notner	1 205		apricorr sition (Name of		ROCKV111	e, MD 2085!					
Baltimore, permit. Pages 1 an Department of Hea Important: If iten		1 Burial 2 Cremation	3 Removal from		crematory or ot	her place)	cemetery,	Date	20c. Location - City or	r Iown, State				
ti Pag tment		4 Donation 5 Other Spe		Ar	dent Ci	cemation	n Svc 03	3/16/2012	Hanover,	MD				
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Inportant: If them 71 is marked other than "natural", or items 23 mr 23s -f shu hilly or other fraumstic event. B. Waster		21. Signature of Funeral Service Li		-7/					uneral Home					
Physician		246 N. Washington St, Rockville, MD 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart												
/Medica Examine	1	failure. List only one cause or Immediate Cause (Final disease or condition resulting in death)	a. Gunshot Wou Due to (or as a co							Between Onset and Death				
	_	Sequentially list conditions,	b											
	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a co	nsequence o	f):									
Band and Transit		events resulting in death) Last	Due to (or as a co	nsequence o	f):									
ਤ ਸ਼ੁਲ		UNPENDED	AMENDED											
876 tificat ng phy as the	N/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outo			etal death	3 Ectopic preg	nancy	23d. Date of deliver Month	y Day Year				
Box 68760, c death certificate be the attending physic ed for use as the bure	sician/Med	1 Yes 2 No 9 V Unkno	~	at time of de	ath	ther (Specify)								
D. B. true de by the gehed f	F	Part II. Other significant condition	O CHROOWI		esulting in the	inderlying cause	e given in Part I	23e Did to	pacco use contribute to	the cause of death?				
cords, P.O. I law requires that the has been signed by the care.	ğ	Multiple Blunt Force In		Jac Hot H		and onlying cads	o givon in rait i.		2 ✓ No 3 Pro					
of Vital Records, ng Physician: The law require the true certificate has been simple threat director, page 2 should be	Completed							24a. Was a autops		utopsy findings available completion of cause of				
He lay	, Lo							perform 1 ✓ Yes 2	med? death?					
Vital Rec sysician: The his certificate director, page	O O	25. Was case referred to medical				26.Pla	ace of Death (Chec			2 110				
Vit.	To B	examiner? 1 Yes 2 No	Hospital: 1 Inpa	atient 2	ER/Outpatient	3 DOA	Other Nurs	sing Home 5 🗌 I	Residence 6 🗸 Othe	er: Scene				
ion of Vit tending Physic eath. Inr: After this	cation:	27. Manner of Death 1 Natural 5 Pendin 2 Accident Investig		njury Y ^{year)}	28b. Time of 0938 hrs		njury at Work? Yes 2 ✔ No		owinjury occurred aulted and shot					
Division Hospital ar Attendia 24 hours after death. Funeral Directur: A stely filled in by the fu	Certifica	2 Accident Investig 3 Suicide 6 Could a 4 Homicide	treet and Number or Relate) ate) ticut Avenue, Kensi	ural Route Number, City										
Division of Vital Records, P.O. Box 68760, To the Hospital in Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici or on the Funeral director, page 2 should be detached for use as the buri	Medical C	29a. Certifier 1 Certifying Phy.	iner: On the basis of e	xamination a					e(s) and manner as sta and place, and due to ti					
3	Me	29b. Signature and title of certifier	and manner state	м.		29c. Lice	nse number		29d. Date signed (Mo	onth, Day, Year)				
		Poti (Iro	mi-PE	llu		0.0	C.M.E.		March 14, 2012					
		 Name and address of person w Patricia Aronica-Pollak 		,	,	900 W. Bal	timore Street,	Baltimore, MD	21223					
Regi	State strar	31. Date filed (Month, Day, Year) WAR 1 9 2012	32. Regis	trar's Signatu	feel									

DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MONTGOMERY-MEADE MARCH 345 AM JOCELYN Medical 4a. Facility Name (if not institution, give street and number) **Examiner** City, Town, or Location of Death 4c. County of Death HOOKINS If Under 24 Hrs. Hours Min. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Director 218-35-2029 1 🗆 M 2 🔀 48 9/14/1963 West Indies "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Gaithersburg Montgomery 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8300 Fairhaven Drive 20877 West Indies 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian, Armed Forces Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 🔀 No 72 hours after Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 🙀 No Specify: Specify: 3 Widowed 4 Divorced Completed Year or Dates. Black permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumante event, the Medical. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12±h Clerk-Kohls Department Store Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ည Alfred Corbett Henriatta Corbett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Verlin Meade/Husband 8300 Fairhaven Drive, Gaithersburg, MD 20877 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ardent Crematory 03/26/2012 | Hanover, MD 22. Name and Address of Facility Snowden Funera Home 21. Signature of Funeral Service Licensee 246 N. Washington St. Rockville, MD 20850 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) adenocarcinoma Medical Due to for as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): the attending physician and thed for use as the buria Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Innead director, page 2 should be detached for use as the buring weight resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23h. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death Day 9 Unknown g 🗌 Unknown Part II. **Other significant condition**s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: ည 1 🗌 Yes Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 1 Natural 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore MD21287 31. Date filed (Month, Day, Year) State

Registrar

19

			Plea	ase Type or						-		_	ble.		
		For State Registrar		State	of Iviaryia		artment of F rtificate of L		ina iv	ientai Hy	giene Reg. N	0.0	112	P-0-4	011.
Dhuaiaia	/	1. Decedent's Name	e (First, Middle	e, Last)						2. Date of De	eath		Year	3. Time	of Death
Physicia Medic			Danie		Meek	ins,	Jr.			March	12	, 20	12	9:30	0 P. M
Examin	er	4a. Facility Name (if					4b. City, Town, or		Death		40	c. County o			
Funeral		Casey Hot 5. Social Security N		6. Sex		. last birthday)	Rockv If Under 1 Year	If Under 2		8. Date of Bir		Mont	9. Birthp	lace (State	e or Foreign
Director		579-32-54		1 X M 2 □ F		85 Yrs.	Months Days	Hours	Min.	(Month, Da			Count		1
show at	ě	Usual Residence of 10a. State	of Decedent 10b. County			ity, Town or Lo	ocation			09/30/	1920	<u> </u>		yland Od. Inside	City Limits
Maryla 28a-f s atified	rect	Maryland	Mon	tgomery	_ I	Potomac	:							1 🗆 🗅	Yes 2 🔀 No
h the la or 2 be no	Funeral Director	10e. Street and Nur					10f. Zip Code				10g. C	itizen of W	hat Coun	try?	
ath wit	uner	2404 Ch:	ilham I		edent Ever in U	10 112	208 Was Decedent of H	_	in2/Spa	cifu Ves or No-		nited			
er dea or ite miner	by Fi	11. Marital Status 1 ☐ Never Marr	ied 2 ☐ Mar	Armed Fr	orces?		If Yes, specify Cuba	in, Mexican,	Puerto I	Rican, etc.)			- America , White, e		
urs aft ural",		3 🕱 Widowed	4 Divorced	If Voc Gi	VO	953	1 Yes 2 X No	Specify:				Specify:	White		
72 hou n "nat Tedica	Completed	(Spe		nt's Education est grade completed		(Give	edent's Usual Occup kind of work done of OO NOT use retired)		of worki	ng	16b.	Kind of Bus	siness/Inc	lustry	
vithin giene. er thai		Elementary/Seco	ondary (0-12)	College (1-4 or 5+)		sonnel Di	recto	r		Fed	leral	Gove	ernme	ent
filed val Hyg	Be c	17. Father's Name (First, Middle, I	Last)		•		18. Mother	's Name	e (First, Middle,	•				
uld be I Ment narke	J.		aniel		Meekins	1	Sr.			Lilli		Ca			
2 sho Ith and 27 is r traun		19a. Informant's Na					ing Address (Street a							ode)	
1 and of Heal item		Daniel L. 20a. Method of Disp	oosition			Place of Disp	osition (Name of			Date		Location - 0		wn, State	
Page ment c ant: If ury or		1 🔀 Burial 2 4 □ Donation		3 Removal fron Specify)			matory or other place Heaven Ce		3/17	7/2012	Si	lver :	Spri	ng, M	D.
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	٠	.21. Signature of Fu	neral Sa rvice I	icensee	0 0	() 2	2. Name and Addres	ss of Facility	DeV	/ol Fun	era	l Hom	е		
	H	23a Part 1 Enter t	he disease of	complications that	caused the dea		0 East De					rsbur	g, M	D. 20 Approxim	
Physician/ Medical Examiner	er	shock, or hear Immediate Cause (disease or condition resulting in death) Sequentially list co- if any, leading to im-	Final on management of the second of the sec	Due to		quence of):	Syndrome							Interval E Onset an	Between
Jeath certificate be executed e attending physician and of for use as the burial transfer	edical Examiner	cause. Enter Under Cause (Disease or that initiated events resulting in death) I	rlying injury s	с	(or as a conse										
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the bu	Physician/Medic	IF FEMALE: 23b. Was decedent in the past 12 I 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?	1 Live	tcome of pregr Birth 2 Fe gnant at time of nown	tal death 3	Control of the contro	÷y				23d. Date Mon		ery Day	Year
s that gned k			_	ons contributing to	death but not re	esulting in the	underlying cause giv	ven in Part I.				use contrib			
equire een si hould	eted	Prostate	Сапсе	r											Unknown
n: The law r ficate has b or, page 2 s	Completed by	25. Was case referre	ed to medical				00 PV	10 11	(0)	1 🗆 Yes	psy ormed?	pr de		mpletion o	gs available of cause of
ysicia is certi directo	To Be	examiner?		Hospital:	Inpatient 2	☐ ER/Outpatie	Oth	er: 4 Nur		me 5 Resi	dence	6 🕱 Other	(Specify)	Hos	pice
eath. eath. or: After thi	Certificate:	27. Manner of Death 1 X Natural 2 Accident	5 Pendir Investi	28a. Date (Mor gation		28b. Time of injury	of 28c. Injury work	y at	2	28d. Describe I					
ital or Att		3 ∐ Suicide 4 ☐ Homicide	6 L Could determ	ined 28e. Place	e of Injury - At I ing, etc. (Speci	nome, farm, st ify)	reet, factory, office			28f. Location (City or Tox			or Rural	Route Nu	mber,
the Hosp hin 24 hou the Funer ripletely fi	Medical	(Check 2 only one) 3	☐ Medical E	Physician: To the I Examiner: On the ba Nurse Practitione	sis of examinati	on and/or inves	stigation, in my opinio e, death occurred at t	on, death occ he time, date	urred at	the time, date a	and plac the caus	e, and due e(s) and ma	to the cau	ise(s) and r tated.	manner stated
12+1		29b. Signature and	rah	Mel	or	CRNI	29c. License				29d. Da	ate signed	Month, D		
		30. Name and address Debrah M: 31. Date filed (Monti	iller,	CRNP, 60	01 Munc	aster	Mill Road	, Rocl	kvil	le, Ma	ryla	nd 20	855		
Stat Registra			R 16 2	2012	Registrar's Sign	1. pa	del.								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend 24a&25 per med cert G926 4/17/12 dk
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death , 2<u>012</u> Physician/ Month Tuck Wai Ng March 17, $\mathbf{a}^{\ M}$ 8:57 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Williamsport Nursing Home Williamsport Washington 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Nov. 19, 1923 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign **Director** 403-56-4882 Malaysia 88 Yrs Usual Residence of Decedent 28a-f show 10a. State 10b. County filed within 72 hours after death with the Maryland item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 1 🗆 Yes 2 🛣 No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11212 Hollywood Road 21740 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Asian 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) 12 College (1-4 or 5+) Teacher Education Be permit. Page 1 and 2 should be file Department of Health and Mental H Important: If item 27 is marked any injury or other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Jee Wong Peh Yong 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margie H. Ng (Wife) 11212 Hollywood Rd. Hagerstown, Maryland 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 ☐ Burial 2 🛛 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Hagerstown Crematory 3-19-2012 | Hagerstown, Maryland 22. Name and Address of FacilityOsborne Funeral Home P.A. 425 S. Conococheague St. Williamsport, MD 21795 23ar Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ ACUTE GASTRO INTESTINAL disease or condition resulting in death) HEMORRHAGE Medical Due to (or as a consequence of) Examiner Esquentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) executed and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical requires that the death certificate be IF FEMALE been signed by the attendin should be detached for use 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 1 Yes 2 L 9 Unknown 2 No 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ASPIRATION RIHOMUJUS Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Director: After this certificate has been siden by the funeral director, page 2 should to 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an the Hospital or Attending Physician: The law autopsy performed 1 ☐ Yes 2 ☐ No Yes 2 🛣 No of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 XNo 욘 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Division 2 Accident
3 Suicide
4 Homicide M Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined within 24 hours a Medical 29a. Certifier 1 🗶 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WILLIAMSPORT, MD 154 N. ARTIZAN ST IED E. HOWE 31. Date filed (Mo State 1 9 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. for State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<u>012</u> Physician/ Nerses Nazarian а м March 22 3:36 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death P.G. Hospital Center Hyattsville P.G. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Funeral 9. Birthplace (State or Foreign Hours Director 213-78-2184 1 XM 2 □ F 62 20, 1950 Feb. Usual Residence of Dec or 28a-f show at 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director must be notified 1 Yes XX No MD Montgomery Olney 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 3532 Dartmoor Lane 20832 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. Armed Forces ò "natural", or 1 Never Married 2 Married 2 X No Yes, Give Baltimore, Maryland 21215-0036 Specify.White 1 ☐ Yes 2 X No Specify. 3 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4 or 5+) Mechanic Automotive Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Nerses Nazarian Ojean Nazarian 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Biros Garabed/Wife 3532 Dartmoor Lane, Olney, MD 20832 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date injury or 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) of Heaven Cemetery Silver Spring, MD 21. Signatule of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 00 University Blvd. W., Silver Spring, any MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examir law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician the bur Physician/Medical as IF FEMALE: for use a 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months? 1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day Year 1 Yes 2 L 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pe 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director: After this certificate h performe 2 🗌 No 1 Yes Completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's 2 No Hospital Other: ပ 1 Tes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending ☐ Accident Investigation 1 Yes 2 No 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) title of cert 29b. Signature completed cause of death (Item 231) (Type, Print)

Registrar DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

MAR 26

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#5perFH. G928.6/27/2012. WS
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician/ Blanche Clayton Newton Feb. 2012 8:00 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Crofton Nursing Home Crofton Anne Arundel 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth **Funeral** 149-24-8843 Days Hours Min (Month, Day, Year) **Director** 24 1 □ M 2 🔀 F Yrs. 77 3/18/1934 NJ Usual Residence of Decedent or 28a-f show notified at death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Xyes 2 No MD Prince Georges Bowie 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? ıral", or items 23a o Examiner must be Funeral 10423 Cleary Lane 20721 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 Married Ves 2 X No within 72 hours after Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Black "natural", 3 Widowed 4 ☐ Divorced Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working ntal Hygiene. ed other than "event, the Mec life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12th Secretary <u>Private Industry</u> Be permit. Page 1 and 2 should be filed Department of Heatth and Mental Hy Important; If item 27 is marked ott any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Harry Clayton Mabel Stewart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cynthia Newton/Daughter 5623 Mews Court Laurel MD 20707 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) Burial 2 □ Cremation 3 □ Removal from State Harmony Memorial:3/2/2012 Landover, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Latimore Funeral Services Signatur of Funeral Service License 2818 E. Baltimore Ave. Baltimore,MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph sician/ disease or condition Atherosclerotic Cardiovascular Disease Years Medical resulting in death) Examiner Dementia Years Sequentially list conditions, Examine Sue to for as a consequence off cause. Enter Underlying Cause (Disease or injury that initiated events and B To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) in the past 12 months? Month Day Vear n signed by the at ald be detached fo Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Osteomyelitis Hip, Tibia 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy performed? Yes 2 X death? 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 XNo 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work' ours after death.

leral Director: Aft
filled in by the fur 1 🗌 Yes 2 🗌 No Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \square Homicide within 24 hours a To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Completely (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signe 2012 D20108 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar <u>Rakesm</u>

31. Date filed (Month, Day, Year)

Gallant Fox Lane

20817

Bowie,

_MD

MD

Arora

4300

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician/ PM Oglebay 3013 Leonard Thomas Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Allegany Lions Center Cumberland Birthplace (State or Foreign Country)
 MD Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth **Funeral** Days (Month, Day, Year) Feb 9, 1932 **Director** 217-28-0576 Usual Residence of Decedent 1 XM 2 □ F 80 or 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director Cumberland MD Allegany 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 21502 USA 901 Seton Drive 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. ò þ 1 Never Married 2 X Married Maryland 21215-0036 1 Yes 2 No Specify. If Yes. Give 3 Widowed 4 Divorced white Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4 or 5+) teacher/coach school system e 1 and 2 should be filed wit of Health and Mental Hygie If item 27 is marked other or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Rena Mae Lewis Charles Andrew Oglebay 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Sue Hurtt Smicksburg PA 16256 19130 Rt. 954 Hwy. N. daughte Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 3/28/2011 MD 4 Donation 5 Other (Specify) Rocky Gap Veterans Cemetery Flintstone 22. Name and Address of Facility Scarpelli Funeral Home, PA of Funeral Service Licensee atur 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final In scare Physician/ (oro nam disease or condition resulting in death) Medical Examiner Sequentially list conditions. Examine tany leading to infirmed cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of The law requires that the death certificate be executed burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death ed by the a detached g Unknown P.O. Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔊 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 🕱 No 24a Was an ate has bage 2 s autopsy performed? Yes 2 To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 🗷 Nursing Home 5 🗌 Residence 6 🗍 Other (Specify) 1 Tes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 1 🗷 Natural 5 Pending 1 Tes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral L Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certi 00033280 esm 30. Name and address of person who fompleted cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

Kent Avenue

Cumberland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra MEND#10a,b,coerFH,3/26/12;BMW,McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 19 2012 14:18 JULIO EDGAR PALMA Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PRINCE GEORGE'S HOSPITAL PRINCE GEORGE CHEVERLY Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Yea] 948 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** Months Days Hours 579-21-5923 **Director** 1 X M 2 D F 63 November 16, Guatemala Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State or other traumatic event, the Medical Examiner must be notified at Director 1X Yes 2 □ No Washington, DG DC None 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5 23a Funeral 20001 1236 11th ST, NW #303 Guatemala ritems Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, Black, White, etc þ 1 Never Married 2X Married ō 72 hours after Baltimore, Maryland 21215-0036 1X Yes 2 □ No Specify: Guatemalan Specify: Latino If Yes, Give Year or Dates "natural" 3 - Widowed 4 - Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working than ' life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Labor Construction, marked other Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Unknown Erminda Palma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .8 27 (Son) 6200 20 Ave Hyattsville, MD 20782 Julio Edgar R Palma Jr. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemeter), clarificary of Other place) 20a. Method of Disposition 1 X Burial 2 Cremation 3 X Removal from State 03/28/12 ¢nral San Miguel Jalapa, Guatemala injury 4 Donation 5 Other (Specify) 22. Name and Address of Facility Santa Cruz Funeral Services, Inc 600 Kennedy St, NW, Washington, DC 20011 otal 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physican/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Siscour tigilly flet exhibitions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of attending physician and for use as the burial transit that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy 3 ☐ Ectopic pregna 5 ☐ Other (specify) Day in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant 9 Unknown Pregnant at time of death 1 Yes 2 g Unknown been signed by the s should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 3 Probably 4 Unknown 1 Yes 2 No 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed has ; page 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 100 ၉ 1 Tes 1 🗌 Inpatient 2 🞾 ER/Outpatient 3 🗌 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Medical Certificate: Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident within 24 hours after death:

To the Funeral Director: / 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title 2012 npleted cause of death (Item 23a) (Type, Print) 30. Name and address of person who con HOSPITAL DRIVE CHEVELLY MS 2018S MA 3001 Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

			For State Registrar	State of Maryla	-	artment c		and Mental Hy	rgiene Reg. No. 20	112	10	149
	Physicia	ın/	1. Decedent's Name (First, Middle, Last	()				2. Date of De	eath	Year	3. Time of [Death
	Medic	cal	John Brenville	Pena				March			7:17	PМ
	Examin	ier	4a. Facility Name (if not institution, give s Suburban Hospital	street and number)		4b. City, Tow Bethe	n, or Location o	of Death	4c. County			
	Funeral		Social Security Number 6. Se.	x 7. Age (In yrs	s. last birthday)	If Under 1 Y				9. Birthp	lace (State or	Foreign
176	Director		437-54-3938 1 Usual Residence of Decedent	X M 2 □ F 73	3 Yrs.	MONTHS	ays Hours	Min. (Month, Da		Count	LA	
	and show lat	Į.	10a. State 10b. County	10c. (City, Town or Loc	ation		SOFOT S	,, 1,500	11	0d. Inside City	/ Limits
	Maryl 28a-f otifiec	irect	MD Montg	omery	Silver						1 🗌 Yes	2X No
	th the 3a or t be n	Funeral Director	10e. Street and Number 1702 Donald Place			10f. Zip Coo			10g. Citizen of W	/hat Coun	try?	
	ath wi	nue	11. Marital Status	12. Was Decedent Ever in I	U.S. 13. V		0902 of Hispanic Orio	gin? (Specify Yes or No-	USA 14 Page	e - America	an Indian	
21215-0036	ırs after de ıral", or it	by	1 Never Married 2 X Married 3 Widowed 4 Divorced	Armed Forces? 1 🖾 Yes 2 🗌 No If Yes, Give Year or Dates 1958-			Suban, Mexican No Specify:	gin? (Specify Yes or No- i, Puerto Rican, etc.)	Black Specify:	k, White, e Vhite	4 -	
15-6	72 hou "natu edica	plet	15. Decedent's Ed (Specify only highest grad		(Give k	ent's Usual Oc aind of work do	ne during most	t of working	16b. Kind of Bu	siness/Ind	lustry	
12	vithin 7 iene. r than the M	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)		NOT use reti		aftsman	0il Inc	lustr	У	
Maryland 2	I be filed w fental Hyg rked othe tic event,	To Be	17. Father's Name (First, Middle, Last) Joseph Frank Per	na Sr.				er's Name (First, Middle, ry Ellen Pi)		
	d 2 should alth and M n 27 is ma er trauma	- 03	19a. Informant's Name/Relationship (Type Ingrid Pena/Wife		19b. Mailin 1702	g Address <i>(Str</i> Donald	eet and Numbe	er or Rural Route Number Silver Spi	er, City or Town, St	tate, Zip C 2090	ode) 2	
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1X Burial 2 Cremation 3 4 Donation 5 Other (Specify,	Removal from State	Place of Dispos cemetery, crem	atory or other	place)	March 15	20c. Location - Silver			
Balti	permit. Departn Imports any inju		21. Signature of Funeral Service License				- 1	ins Funeral BlvdW, S		_		0901
	Ph sician		23a. Part 1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final	lications that caused the de e cause on each line. Left Hemoth		r the mode of	dying, such as	cardiac or respiratory ar	rrest,		Approximate Interval Betwo	een
•	Medical		disease or condition resulting in death)	Due to (or as a conse						+		
	Examiner	<u>.</u>		Pleural Eff							hours	
	p ₀	Examiner	if any, leading to immediate cause. Liner Uniterlying Cause (Disease or injury	Due to (or as a conse		rdiova	scular	Disease			years	
	te be executed hysician and he buriat trees		that initiated events resulting in death) Last	Due to (or as a conse								
68760	icate k j phys	ledic		d								
Box 68	Attending Physician: The law requires that the death certificate be executed er death. sctor: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the buristions.	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of preg 1 ☐ Live Birth 2 ☐ Fe 4 ☐ Pregnant at time o 9 ☐ Unknown	etal death 3 🗌	Ectopic pregr Other (specify			23d. Date Mon	e of delive	ry Day Ye	ar
1917 ds, P.O.	requires that the des been signed by the s should be detached	d by Ph	Part II. Other significant conditions cor	ntributing to death but not r	esulting in the ur	nderlying cause	e given in Part I	200.2101	obacco use contri			
2 <i> 9</i> ecords,	v requi	lete						24a. Was	an 24b. W	/ere autop	sy findings av	ailable
2 E	ician: The law certificate has l rector, page 2 s	Completed by	25. Was case referred to medical			-	Discost Dest	auto perfo 1 \subseteq Yes	psy property description of the property of th	rior to con eath?	npletion of cau	use of
$\frac{\mathcal{J}}{\mathcal{N}}$	ysician: is certific director,	To Be	evaminer?	lospital:	X ER/Outpatient		Other:	rsing Home 5 \square Resid	dence 6 Other	r (Specify)		
h m	ath. ath. r: After th	Certificate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. li	njury at vork? Yes 2	28d. Describe h	now injury occurred			
Division	• Hospital or Attending I 24 hours after death. • Funeral Director: After etely filled in by the funer		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, stre	et, factory, offi	ce	28f. Location (\$ City or Tow	Street and Number	r or Rural I	Route Number	r,
En	To the Hospital or Attend within 24 hours after deatl To the Funeral Directors. completely filled in by the	Medical	(Check 2 L. Medical Examin	cian: To the best of my kno er: On the basis of examinati Practitioner: To the best o	ion and/or investi	gation, in my o	pinion, death oc	curred at the time, date a	and place, and due	to the caus	se(s) and manr	ner stated.
	10+1		29b. Signature and title of certifier	D mi			ense number 31027		29d. Date signed March			
	(10)		30. Name and address of person who co P. O'Brien, MD				ad, Bet	hesda, MD 2	20814			
	Stat Registra	C	31. Date filed (Month, Day, Year) WAR 14 2012	32. Registrar's Sign	far	ジ						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2012 Physician/ Phung Nga March рм 5:42 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday, **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 213-13-4748 **Director** 1 □ M 2 🛣 F 89 June 20, 1922 Vietnam Usual Residence of Decedent 28a-f shov 10a. State 10b. County the Maryland at 10c. City. Town or Location 10d. Inside City Limits Directo notified MD Howard Clarksville 1 Yes 2 K No 10e. Street and Number ō 10f. Zip Code 10a. Citizen of What Country? must be Funeral 23a 6475 Galway Drive 21029 Vietnam and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces?

1 Yes 2 X No Black, White, etc. 9 2 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify Asian Yes "natural" 3 X Widowed 4 Divorced Specify: Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker 6 Own Home of Health and Mental Hygie f item 27 is marked other r other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Hoan Thuan Phung Khanh Diec 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kequan Luu/Son 6475 Galway Drive, Clarksville, MD 21029 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a Department of H Important: If ite any injury or ot Date 1 🖾 Burial 2 🗌 Cremation 3 🔲 Removal from State March 23 Gate of Heaven Cemetery 4 Donation 5 Other (Specify) Silver Spring, MD 2012 21. Signature of Funeral Service Licenses Prancis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver 20901 MD Spring. Part 1. Inter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1 Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Multi-Organ Failure disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sepsis Sequentially list conditions, if any, leading to immediate caus. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) use as the burial-transit Ischemic Colitis and Due to (or as a consequence of) attending physiciar Physician/Medical requires that the death certificate be Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒No
9 ☐ Unknown ξ Month Day Year 5 Other (specify) Pregnant at time of death detached the 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? þ should be Severe Malnutrition Division of Vital Records, 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Yes 2 No certificate the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 X No မှ 1 🔀 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred X Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of certifig 29c. License number 29d, Date signed (Month, Day, Year D63343 March 19, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Irina Rúban, MD 1500 Forest Glen Road, Silver Spring, MD 20910

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year

WAR 20

			Plea	ase T									-		e Legible) .	
		For State			State c	ot IVI	arylan						Mental H	ygien	e	0 :	0.1.5
	_	Registrar 1. Decedent's Name	o (Eint Middle	l actl				Ce	піпса	te of E	Jeatr		10011	Reg. N	lo. 2	2	
Physicia		Claire T			want.								2. Date of D Month		ay Year		me of Death
Medic Examin		4a. Facility Name (if				nber)			4b. Cit	y, Town, or	Locatio	n of Death	1. 3_	T 2	L1 20]		:05 P ^M
LAGIIIII		Manor Ca	re Whea	aton		,				lver					ont gome		
Funeral		5. Social Security N		6. Sex	M 0 177 F	7. Ag	e (In yrs. la	ast birthday)	If Und	If Under 1 Year If Under 24 Hrs. 8, Date of Birth					9. E	irthplace (S	tate or Foreign
Director		217-36-6		1 🗆	M 2 X F		73	Yrs.	WOITER	Days	Tiodis	IVIII I.	3-14-1	938		ountry) <u>Ne</u>	w York
show dat	ř	Usual Residence of 10a. State	10b. County				10c. City	, Town or Lo	ocation							10d. Insi	de City Limits
taryla 3a-f s iffied	ect	MD	Mont	eome	rv			Rockv	i11e								Yes 2 No
th the Maryland 3a or 28a-f shov t be notified at	٥	10e. Street and Nur								ip Code				10g. (Citizen of What 0	Country?	
s 23a	Funeral Director	5801 Nic	holson	Lan	e #803	3			20852					Uni	ited Sta	tes	
death item	Fur	11. Marital Status		1	2. Was Dece Armed Fo	edent 8	Ever in U.S	3. 13.	Was Dec	edent of Hi	ispanic (Origin? (Sp	ecify Yes or No Rican, etc.)		14. Race - An	erican India	ın,
after Il", or xami	d b	1 ☐ Never Marr 3 ☐ Widowed			Armed Fo 1 ☐ Yes If Yes, Giv	re	No			2 X No			,		Black, White, etc. Specify: White		
flied within 72 hours after death with the Maryland at Hygiene. d other than "natural", or items 23a or 28a-f sho ivent, the Medical Examiner must be notified at	Be Completed by		15. Decede	nt's Educ	Year or Da			16a, Dece	dent's Us	ual Occup	ation			T 16h	Specify: White 16b. Kind of Business Industry		
n 72 h e. an "n Medi	du		ecify only highe	est grade	completed) College (1		27)	(Give	kind of w	ork done d se retired)		ost of work	king	100.	Killa of Basilles	s muusiry	
withi giene per th	၁ ၁	Elementary/Sec	oriday (o 12)			, 0, 0	J.,	Admi	nist	rativ	e As	sista	ant	I	ederal	Gover	nment_
filed tal Hydra of other	To Be	17. Father's Name (Last)							18. Mo	ther's Nan	ne (First, Middle	e, <i>Maid</i> e	n Surname)		
uld be 1 Men narke natic	-	Hyman Fla					-						Goldst			_	
2 sho th and 77 is r traun		19a. Informant's Na				\ \ \ \ \									or Town, State, 2		
and Healt tem 2		Perrin Pa 20a. Method of Disp		ant	- SC)N	20b. P	9048 lace of Disp			prin	g A	Date		Vegas,		
age 1 ent of nt: If i		1 ☐ Burial 2	Cremation		emoval from	State	C	emetery, cre ional	matory or	other plac	′	2 16	5-2012			,	
permit. Page 1 and 2 should be filed within 72 hours after death with i Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must boone.		21. Signature of Fu			Edwa	rd				and Addres	-				ls Chur -Goldbe		irginia
permi Depar Impo any ir		1 4	W	2	LOWE	#M(Sage 00910	1	170 I	Rockv	ille	Pike			e, Mary		20852
		23a. Part 1. Enter t	the disease, or art failure. List o	complic	ations that o	caused	d the death									Appro	ximate al Between
Physician/		Immediate Cause (disease or condition	(Final					enal :	Disea	ase							and Death
Medical Examiner		resulting in death)		r"	Due to	(or as	a consequ	ence of):									
_	er	Sequentially list co	onditions,	b.	Diab		e S a consequ	anaa afti		•	7						
os tigo	Examiner	if any, leading to in cause. Enter Unde Cause (Disease or	erlying injury		Due to	(UI as	a consequ	lerice oi).									
executed an and ria transi		that initiated event resulting in death)	S	C.	Due to	(or as	a consequ	ence of):									
cate be ex physician s the buria	lical			L d.													
tificat ng ph as th	Mec	IF FEMALE:		T			_									1	
th cer ttendi or use	ian/	23b. Was decedent in the past 12		23		Birth	2 Feta	Ideath 3	Ectopic	pregnanc	y				23d. Date of o		Voor
e dear the ar	ysic	1 Yes 2 9 Unknown	∆ No		4 ☐ Preg 9 ☐ Unkr		at time of d	eath 5 l	Other (specify)					Month	Day	Year
hat th ed by detac	Completed by Physician/Medi	Part II. Other signif	ficant condition	ons cont	ributing to d	eath b	out not res	ulting in the	underlying	g cause giv	/en in Pa	rt I.	23e. Did	tobacco	use contribute	to the cause	of death?
uires t n sign ild be	q pe												1 🗆	Yes	2 X No 3 □	Probably	4 🗌 Unknown
v requ	plet												24a. Wa		24b. Were a	utopsy find	ings available
he lar te har	mo												per	opsy formed? s 2X	death?		n of cause of
ian: T artifica ctor, p	Be C	25. Was case referre	red to medical	T						26. Pla	ace of D	eath (Chec	k only one)	, 2A-	1101	03 2 111	
hysic his ce	2	1 🗆 Yes 2 💆	X No	Но				ER/Outpatie		DOA Othe	er: _4 [X	Nursing H	ome 5 Res	sidence	6 Other (Spe	ecify)	
Jing F J. After 1 funera	Certificate:	27. Manner of Death 1 X Natural	5 Pendir		28a. Date (Mon	of inju th, Daj	y, Year)	28b. Time o injury		28c. Injury work	?		28d. Describe	how inj	ury occurred		
deatl ctor: y the	rtific	2 Accident 3 Suicide	6 Could	not be	28e. Place	of Init	urv - At ho	me, farm, st	M reet. facto		Yes 2	□ No	28f Location	Street	and Number or F	ural Route I	Vumber
al or As after I Dire		4 Homicide	determ	iinea	buildi	ng, etc	c. (Specify)	,	.,,			City or To			arar riouto r	rambol,
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but	Medical	29a. Certifier 1 (Check 2	X Certifying	Physici	ian: To the b	est of	my knowl	edge, death	occured	at the time,	, date an	d place, a	nd due to the o	ause(s)	and manner as s	tated.	
the H hin 24 the F the F	Me	only one) 3	3 ☐ Certifying	Nurse I	Practioner:	To the	best of my	knowledge,	death occ	urred at the	e time, da	ate and pla	ce, and due to	the cause	e(s) and manner a	s stated.	u manner statet
P 1 1 2		29b. Signature and	title of certifier	1/1	4	1/	2	m		9c. License				29d. [late signed (Mor	th, Day, Yea	r)
		20 North 201	900	wh= :==	aplated	<u>ر</u>	looth "	02=) T	- 1	- ·	٠ .	, 50'		-	//3/	/	
		30. Name and address Lya Mall					,	, , , , ,		renue	ז.חע	LJ 2 C	hingto	n DC	20027		
Stat	е	31. Date filed (Mont	th, Day, Year)					-		cirue	TAM	, was	mill LO	טע וו	2003/		
Registra		MAR	₹ 202	012	Sent	رمد	, B.	ure for									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. nd #10a-f Per FH G927 5/18/2012 JH
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Da 2012 Year March 17. Paul David PARK 6:00 AM 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Brooke Grove Nursing & Rehab Center Sandy Spring Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 108-22-8170 1 🗷 M 2 □ F 93 Poland June 29, 1918 Usual Residence of Decedent 10a. State DC 10c. City, Town or Location Washington 10d. Inside City Limits XX Yes 2 XNo Maryland Montgomery Silver Spring 10e. Street and Number 5111 Connecticut Ave. 10f. Zip Code 10g. Citizen of What Country? 20910 20008-2004 United States 708 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11 Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married 1 Yes : white 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced WW II Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Clinical Psychologist Psychology 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Max Goldstein Toba Wolberger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marilyn Park, Daughter 805 Gist Avenue, Silver Spring, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 Nurial 2 Cra 4 Donation Other (Specify) Lebanon Cemetery: 03/18/2012 Adelphi. MD Signature a Lidensee forchinsky Hebrew Funeral Home 20012 254 Carroll St., NW. Washington, Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between

Physician Medical Examiner

Physician/

Medical

Examiner

Funeral

Director

28a-f show

ō

23a

items

ō

"natural",

ed other than "natu event, the Medical

permit. Page 1 and 2 should be filed wir Department of Health and Mental Hygie Important: If item 27 is marked other 1 any injury or other trouss.

72 hours after death

Baltimore, Maryland 21215-0036

notified at

Examiner must be

Director

Funeral

þ

Completed

Be

ပ

as the burial-

requires that the death certificate be executed

To the Hospital or Attending Physician: The

Division of Vital Records, P.O. Box 68760

Examiner and attending physician Be Completed by Physician/Medical signed by the has page 2 After this certificate မှ tely filled in by the funeral Medical Certificate: within 24 hours after deatl To the Funeral Director..

disease or condition	Stroke	Weeks	
resulting in death)	Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):		
that initiated events resulting in death) Last	Due to (or as a consequence of):		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3 Ectopic pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)		23d. Date of delivery Month Day Year
	tributing to death but not resulting in the underlying cause given in Part I. Bphagia, Renal Insufficiency,		o use contribute to the cause of death? 2 No 3 Probably 4 Unknown
Hypernatremia		24a. Was an autopsy performed?	
25. Was case referred to medical	26. Place of Death (Check of	only one)	
1 LI Yes 2 LZHNO	ospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☑ Nursing Hom	ne 5 🗆 Residence	6 ☐ Other (Specify)
27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	28a. Date of injury (Month, Day, Year) 28b. Time of injury M 1 ☐ Yes 2 ☐ No	8d. Describe how inj	ury occurred
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	and Number or Rural Route Number, te)	
29a. Certifier 1 XCertifying Physic	cian: To the best of my knowledge, death occurred at the time, date and place, and	d due to the cause(s)	and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

D 0.057630

10301 Ceorgia Avenue, Suite 209, Silver Spring, MD

29d. Date signed (Month, Day, Year,

March 17.

2012

20902

DHMH 17 Rev 06-2011

State

Registrar

Ot

only one) 29b. Signatu

Anuradha Arun,

MAR 19

31. Date filed (Month, Day, Year)

un, M:

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

			For	State of N	/larylanc	d / Departm			Mental Hy	giene		
			State Registrar			Certifica	ate of De	eath		Reg. No.		
	Physicia	n/	Decedent's Name (First, M	liddle, Last)			•	_	2. Date of Dea Month	Day	Year	3. Time of Death
	Medic	al	John Fld			Payto		2r.	March	22 0	3019	17 40PM
	Examin	er		ution, give street and number)				ocation of Death		4c. Cour	ity of Deatl	n
	Funeral		5. Social Security Number	topkins tosa	ge (In yrs. las		der 1 Year 1	f Under 24 Hrs.	8. Date of Birt	h	g. Birt	hplace (State or Foreign
	Director		568-82-0113	1 X M 2 □ F	65	Yrs. Monti	ns Days	Hours Min.	(Month, Day	v, Year)	Cor	intry)
	D WO		Usual Residence of Deceder 10a, State 10b, Con						Dec.27	,1946	Cal	ifornia
	nyland -f sh	ctol		,		Town or Location						10d. Inside City Limits
	r 28a notif	Dire	DC N/ 10e. Street and Number	A	Wa	shington	Zip Code			40.000		1 X Yes 2 No
	/ith th 23a o st be	Funeral Director	1824 Phelps P	lace, NW			200.08			10g. Citizen o		-
	ems r mu	nne	11. Marital Status	12. Was Decedent		13. Was De	cedent of Hispa	anic Origin? (Sp	ecify Yes or No-	14. B	ace - Amer	ican Indian,
တ္တ	ter de or it	by F	1 Never Married 2	Married Armed Forces		If Yes, s	pecify Cuban, I	Mexican, Puerto	Rican, etc.)		lack, White	
8	ursaf :ural" al Exa	ted	3 Widowed 4 Divo	orced Year or Dates.		1 LJ Yes	2 X No	Specify:		Spec	ty:	rican
5-	72 ho n "nat ledica	ldr lble		cedent's Education highest grade completed)		16a. Decedent's U (Give kind of	work done duri	on ing most of worl	ing	16b. Kind of		
21215-0036	ithin ene. r thar	Completed	Elementary/Secondary (0-	-12) College (1-4 or 5+	5+)	life. DO NOT Lawy	· ·			NAACP	Lega] Fund	l Defense
D D	Hyg othe	Be	17. Father's Name (First, Midd			naw		8. Mother's Nan	ne (First, Middle,	Maiden Surna		
/lar	d be f denta arked arked	오	John Adolphus	s Payton, Sr.				Inah Ma	e Smith			
lan	shoul and h is ma		19a. Informant's Name/Relati	ionship (Type, Print)		19b. Mailing Addr	ess (Street and	i Number or Rur	al Route Number	, City or Town	State, Zip	Code)
≥ .	ind 2 lealth m 27		Gay J. McDoug	gall/Wife	7	1824 Phe		ce, N.W	. Washi	ngton,	DC 20	0008
Baltimore, Maryland	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants I fire Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 Durial 2 X Crema	atjon 3 ☐ Removal from Stat	e cer	ace of Disposition (I metery, crematory o	r other place)	3/28	Date / 2012	20c. Locatio	n - City or	Town, State
tim	it. Pag ntmer rtant: njury		4 Donation 5 Oth		Ches	apeake C		y :		Beltsv	ille	, MD
Bal	permit Depar Impor any in		21. Signature of Funeral Serv	rice ensee								ce, Inc. C. 20012
			23a, Part 1. Enter the disease	se, or complications that cause	ed the death						011,50	Approximate
	h, sician/		shock, or heart failure. L Immediate Cause (Final	List only one cause on each lin	ne.		odo or dyring, c	out a di	or roopiratory air	001,		Interval Between Onset and Death
	Medical		disease or condition resulting in death)	a. One to Or as	a conseque	nce of:					-	
	Examiner			Myl	tiale	myela	ma					
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a onseque							
4		Examiner	Cause (Disease or injury that initiated events	с								
	physician and stress the burial transit	al E	resulting in death) Last	Due to (or as	a conseque	nce of):						
90	ohysic the b	edical		d								
89	ding	Ň	IF FEMALE:	23c. If yes, outcome	e of pregnance	CV				00.11		
Box 68	atten I for u	iciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live Birth 4 ☐ Pregnant	2 Fetal of	death 3 🔲 Ectop					Date of deli Ionth	Day Year
	y the	Physician/M	9 Unknown	g □ Unknown								
Records, P.O.	ned b	by P	Part II. Other significant con	nditions contributing to death	but not result	ting in the underlyir	ig cause given	in Part I.	23e. Did to	bacco use co	ntribute to	the cause of death?
ds,	en sig	ted							1 🗆 ነ	res 2 No	3 🗌 Pr	obably 4 🗆 Unknown
Sor	as ber 2 shc	Completed							24a. Was a			opsy findings available ompletion of cause of
Re	certificate has b lirector, page 2 s	5							perfor	med? 2 □ No	death?	2. No
<u>ta</u>	ciali: ector,	Be	25. Was case referred to medi examiner?	Hospital:			Lou	of Death (Chec	k only one)			
>	this c	2	1 Yes 2 No	1 X Inpa 28a. Date of inj		R/Outpatient 3 8b. Time of			ome 5 Resid			fy)
n o	th. After fune	cate	1 💢 Natural 5 ☐ Pe	ending (Month, Da	ay, Year)	injury M	28c. Injury at work?	s 2 🗆 No	28d. Describe h	ow injury occi	rred	
Division of Vital	r deal c tor :	Certificate:	3 Suicide 6 Co	vestigation ould not be etermined 28e. Place of In	jury - At hom	ie, farm, street, fact		5 2 100	28f. Location (S	treet and Num	ber or Rura	al Route Number.
	s after I Dire		4 LI Homicide dei	building, e	tc. (Specify)		,,	ļ	City or Tow		20, 0, 1,0,1	a riodio ridinosi,
_	The rospinal or Australia Figurean: The law requires that the death centificate be executed thin 24 hours after death. The Funeral Director: After this certificate has been signed by the attending physician are mpletely filled in by the funeral director, page 2 should be detached for use as the burial to still the control of the funeral director.	Medical	29a, Certifier 1 Certifi	fying Physician: To the best o	f my knowled	dge, death occurred	at the time, d	ate and place, a	nd due to the ca	use(s) and ma	nner as sta	ited.
j	within 24 ho	Mec	only one) 3 L Certif	cal Examiner: On the basis of fying Nurse Practitioner: To the	examination a he best of my	and/or investigation, knowledge, death o	in my opinion, o ccurred at the t	death occurred a time, date and pl	t the time, d <i>a</i> te <i>a</i> r ace, and due to th	nd place, and one cause(s) and	ue to the c manner as	ause(s) and manner stated. stated.
Ė	2 ≥ 2 0	200	29b. Signature and title of cer	tifier 1			9c. License nu	ımber		29d. Date sign	ed (Month,	Day, Year)
	20		Rom	16ml			RES !	000		larch	22	2012
			30. Name and address of pers	/			V - V /	VC - C)	G 111	1.1		1 21257
	Stat	0	31. Date filed (Month, Day, Yea	ar) B2. Registr	rar's Signatill	600 Nor	OM Mt	to 371	Doutin	ore M	arylo	nd 21287
	Stat Registra	e	MAR 27	2012	. 4.	pare						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #6 Per FH G926 4/16/2012 JH State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day2012 Year March 24, Mossie Palmer 12:15 Elv Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Manor Care Health Services **Pethesda** Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral 7. Age (In yrs. last birthday) 8. Date of Birth M 2 XX Days Hours 415-18-1213 94 Jan. 1918 CT Director Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD. Montgomery Silver Spring 1 Yes 2 V No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2105 Cascade Road 20902 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🕅 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 No Specify 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Secretary US Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Andrew Jefferson Ely Ruth Maynard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) J. David Palmer/Son 19 Stoneridge Drive, New Freedom, PA 17349 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State March 27 Parklam Memorial Park 1 Burial 2 Cremation 3 Removal from State Rockville, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licer Collectioneral Services, P.A. <u>4110 Aspen Hill Road, Suite 100, Rockville, MD 20853</u> 23a. Part 1. Enter the disease, replications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between shock, or heart failure. Lis Immediate Cause (Final Onset and Death Physician/ Coronary Artery Disease disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin and Cause (Disease or iinjury that initiated events resulting in death) Last that the death certificate be executed Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown 4 Pregnant at time of death 9 Unknown Month Day P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) 1 ☐ Yes 2 1 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After the completed filled in by the funeral 28c. Injury at Certificate: 28d. Describe how injury occurred 1 🗶 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation
6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 3/26/12 00057124 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Truong Bao, MD 10110 Molecular Drive, Suite 206, Rockville, MD 20850 31. Date filed (Month, Day, Year) 2. Registrar's Signature State MAR 27 Registrar

DHMH 17 Rev 7/2009

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month ELIZABETH D. RIGOLI 3/8/2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS ANNE ARUNDEL 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 🗓 F Davs Hours 87Tt, P1931 Director 577-44-8685 80 Usual Residence of Decedent 28a-f show 10a. State aţ 10b. County 10c. City, Town or Location Director ms 23a or 28a-f s must be notified MARYLAND ANNE ARUNDEL ANNAPOLIS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1836 MILVALE ROAD 21401 UNITED STATES 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. item 27 is marked other than "natural", or iten other traumatic event, the Medical Examiner þ 1 Never Married 2 Married 1 ☐ Yes 2 🕅 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: WHITE 3 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 EDITOR 4 PUBLISHING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked o ပ WILLIAM H. DUVALL ELIZABETH MILES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 sl ment of Health a WILLIAM LUIGI RIGOLI/HUSBAND 1836 MILVALE ROAD ANNAPOLIS, MD 21401 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, MARGARETS CEMETERY 20c. Location - City or Town, State Department of Important: If it any injury or o 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) /2012 ANNAPOLIS, MARYLAND HELFENBEINSE FREWLAST CREMATION ES FONERALLOWS 21. Signature of Funeral Service Lie 814 BESTGATE ROAD ANNAPOLIS, MD 21401 Ja P 11. Enter the dise le, complications that caused shock, or heart failure. It only one cause on each line. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final Physician/ Congestive disease or condition resulting in death) Medical Due to (o as a consequence of): Examiner ronury Sequentially list conditions cause. Enter Underlying Cause (Disease or iinjury Dik to (or as a consequence of): and -transit requires that the death certificate be executed y psnutremia that initiated events resulting in death) Last Due to (or as a consequence of): physician a Physician/Medical neumonia Box 68760 attending p 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No signed by the a Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ fibrillation Records, Completed Cerebral vasculur 24a. Was an has autopsy performe Depression and Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate; (Month, Day, Year) 1 Natural 5 Pending 1 Yes 2 Accident Investigation 6 Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a, Certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

3. Time of Death

8:25

10d. Inside City Limits

Interval Between

Onset and Death

1 🗌 Yes 2 💢 No

9. Birthplace (State or Foreign

MARYLAND

Black, White, etc.

 P^{M}

23d. Date of delivery Day Month 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. medical Hospitalist 03 110 060390 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANNAPOLIS ABER ARUNDEL MEDICAL CENTER ANNE MO 3 2012 **ORIGINAL**

Registrar

State

		Ple	ase Type or P AMEND State of	rint in ITEM#2 Marylan	Black II Ob per id/Dep	ndelible Inl FH, G926, artment of 1	. Ensure 4/5/2012 lealth and M	VII Copies WS Mental Hyg	Are Legiene	gible.	
Physicia	n/	State Registrar Decedent's Name (First, Middle)	e, Last)		Cei	rtificate of E			Reg. No.	0 2 Year	3. Time of Death
Medic Examin	al	Solom Or 4a. Facility Name (if not institution	n, give street and numbe	r)		4b. City, Town, or	Location of Death	03	2. I 4c. Count	2012 y of Death	
Funeral		5. Social Security Number	6. Sex 7.	Age (In yrs. I	g to N ast birthday)	If Under 1 Year		8. Date of Birth)	g, Birth	onery place (State or Foreign
Director		194-18-3621 Usual Residence of Decedent	1 2 M 2 □ F	87	Yrs.	Months Days	Hours Min.	April Day	13,1924	Penn	Sylvania
/laryland :8a-f sho tified at	Director	10a. State 10b. County Maryland Mon	tgomery	10c. Cit	y, Town or Lo		lver Spri	ing			10d. Inside City Limits 1 ☐ Yes 2 🂢 No
with the I 23a or 2 ist be no	eral Di	10e. Street and Number	Notley Road	1		10f. Zip Code	20905		10g. Citizen of	What Cou	· ·
r death vor items	by Funeral	11. Marital Status 1 □ Never Married 2 ☒ Ma	12. Was Decede Armed Force	nt Ever in U.S	S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Sp	ecify Yes or No- Rican, etc.)			can Indian,
ours afte atural", c	eted b	3 Widowed 4 Divorced	If You Give	(4)(4)7	. 1	1 Yes 2 X No			Specif		White
ithin 72 h ene. r than "na the Medic	Completed		est grade completed) College (1-4	or 5+)	(Give	dent's Usual Occupa kind of work done d O NOT use retired) Homema	luring most of work				Home
oe filed wantal Hygi ced other cevent, t	To	17. Father's Name (First, Middle,	Last) Oraham Roser	thal		Homena	18. Mother's Nam		Maiden Suman Wenits	ne)	nome
S should the and Me T is mark traumatic		19a. Informant's Name/Relations Suzanne Rosent	ship (Type, Print)			ng Address (Street a		al Route Number,	City or Town,	State, Zip	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: I frem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 X Burial 2 Cremation 4 Donation 5 Other (3 ☐ Removal from St	T.		position (Name of matory or other place morial Gh	- i		20c. Location Olney	- City or 1	own, State
permit. P Departm Importar any injur once.		21. Signature of Funeral Service		00	22	2. Name and Addres	ss of Facility Hir	res-Rina	ldi Fur	ieral	Home, Inc. g,MD 20904
		23a. Part 1. Enter the disease, shock, or heart failure. List	complications that cau nly one cause on each	sed the deat line.	h. Do not ent	er the mode of dying	g, such as cardiac	or respiratory arre		pich	Approximate Interval Between
hysician/ Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or	as a consequ	uence of):	Arter	J DIS	ease		-	Onset and Death
_	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Discorpe or Signing)									
an and ria free;	l Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to (or	as a consequ	uence of):						
ircate be g physicias the bu	fedica		d								
to the hospital or Attending Priysician: The law requires that the death certificate be ex- within 24 hours affordeath. To the Funeral Director, After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the buria	Completed by Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcor 1 ☐ Live Bir 4 ☐ Pregnar 9 ☐ Unknow	th 2 🗍 Feta it at time of a	aldeath 3	Ectopic pregnanc Other (specify)	ry			ate of deli-	very Day Year
ures tnat t signed b Id be deta	d by P	Part II. Other significant conditions Failure to	ons contributing to deat	h but not res	sulting in the u	underlying cause giv	ren in Part I.	1			the cause of death?
e law reque has beer ge 2 shou	mplete	Atrial Fi	brillatio	7				24a. Was a autops perfori	sy med3	prior to co death?	opsy findings available ompletion of cause of
cian: Ir ertificat ector, pa	Be	25. Was case referred to medical examiner?	Hospital:				ace of Death (Chec	1 🗌 Yes k only one)	21 No	1 🗌 Yes	2 L No
rnysi this c ral dire	2	1 Yes 2 No 27. Manner of Death	1 ☐ Inp		ER/Outpatie	nt 3 DOA Othe	4 Nursing H	ome 5 Reside			iy)
ttending death. :tor: After r the fune	Certificate:	1 Natural 5 Pendi 2 Accident Invest 3 Suicide 6 Could	ng (Month, igation	Day, Year)	injury	M 1 □		28d. Describe ho			
ortal or A curs after eral Direc illed in by		4 ☐ Homicide deterr	building,	etc. (Specify	()	eet, factory, office		City or Town	n, State)		al Route Number,
tne riosi hin 24 ho the Fune npleted f	Medical	(Check 2 Medical only one) 3 Certifyin	g Nurse Practioner: To	of examination	n and/or inves	tigation, in my opinio death occurred at the	n, death occurred a e time, date and pla	t the time, date an	d place, and de	ue to the ca	ause(s) and manner stated.
10+1		29b. Signature and title of certifie		CRN	P	29c. License	2 4 1 2	2	29d. Date signe		Day, Year)
		Allion	ilin 1	108	E.30	fferson	S+. R	ockville	e, Mo	2	0852.
Stat Registra		31. Date filed (Month, Day, Year)	2012 Regi	strar's Signa	ure	Nes.					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 20,2012 THELMA M. 1:50 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Rockville Shady Grove Adventist Hospital Montgomery Social Security Number 8. Date of Birth 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months 1 □ M 2 🛛 F Hours July 5,1931 Pennsylvania **Director** 053-26-0089 80 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland Director Maryland Montgomery Gaithersburg 1 X Yes 2 No ò 10g. Citizen of What Country? er than "natural", or items 23a on the Medical Examiner must be by Funeral 20877 United States 333 Russell Ave. #209 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 X No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: should be filed within 72 hours aft and Mental Hygiene. is marked other than "natural", White If Yes, Give 3 x Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retiged) Elementary School Teacher 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hazel P. Pratt John Carl Hinkle ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1001 E. Brentwood Dr. Morristown, TN 37814 19a. Informant's Name/Relationship (Type, Print) Health a Gordon F. Lowery (Nephew) or other 20a. Method of Disposition 20b. Place of Disposition (Name of Mar. Date 22, 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott cemetery, crematory or other place) 1 🔲 Burial 2 🛣 Cremation 3 🗔 Removal from State 2012 Alexandria, VA 4 Donation 5 Other (Specify) Metropolitan Crem. 21. Signature of Fugeral Service License ELMA 22. Name and Address of Facility DeVol Funeral Home Curtis: (M01116)10 East Deer Park Dr. Gaithersburg, MD 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Mellmonice disease or condition Medical resulting in death) Examiner Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate Exami Cause (Disease or linjury that initiated events burial-tran and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical b Hospital or Attending Physician: The law requires that the death certificate be-24 hours after death.
Funeral Director: After this certificate has been signed by the attending physicis Division of Vital Records, P.O. Box 68760 as the IF FEMALE use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy detached for in the past 12 months?
1 ☐ Yes 2 🗷 No Month Pregnant at time of death 9 Unknown 9 Unknown To the Hospital or Attending Physician: The law requires that the within 24 hours after death.

To the Funeral Director, After this certificate has been signed by a completed filled in by the funeral director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an autopsy perform Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 ☐ Yes 2 🗷 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural injury 5 Pending Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🙎 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 00062435 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rockville, MD 20850 10110 State

Registrar

12

イえ

50%

MARCH

ROGERS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 19, Day 2012 Year Physician/ J. Betty Rice 2:25A. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 8803 48th Avenue Prince George's College Park . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth

Manth, Day, Year 30

1930 9. Birthplace (State or Foreign . Age (In yrs. last birthday, **Funeral** Days 1 □ M 2 🂢 F 216-28-3380 81 Maryland Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10b. County 10c. City, Town or Location Director 1 Yes 2 □ No Maryland Prince George's College Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20740 United States 8803 48th Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 X Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Clergy Church 18. Mother's Name (First, Middle, Maiden Surname)
Daisy Huchings 17. Father's Name (First, Middle, Last) Harry Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co 8803 48th Avenue College Park, Maryland 20740 Stephen E. Rice -son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date veterans Cemetery 3/29/2012 1

Burial 2 □ Cremation 3 □ Removal from State Cheltenham, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensy Bonald AvessBorgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician, Aspiration Pneumonia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Cerebrovascular Accident Sequentially list conditions, Examine If any, leading to himmediate cause. Enter Underlying the burial-trapsit Cause (Disease or iinjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death for use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 X No Day Month Year Pregnant at time of death signed by the a d be detached f g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Recurrent Urinary Tract Infection; Type2 Diabetes 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown Completed page 2 should Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? Yes 2X No 2**X** No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 **X** No Other: 4 Nursing Home 5X Residence 6 Other (Specify) 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending injury 1 Yes 2 No within 24 hours after death.

To the Funeral Director: A

Example ted filled in by the fu ☐ Accident ☐ Suicide Investigation
6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Registrar

State

29b. Signature and title of cortifier

Gaby Tesfaye,

31. Date filed (Month, Day, Year)

who completed cause of death (Item 23a) (Type, Print)

82. Registrar's Signature

29c. License number

D52555

M.D. KP 6525 Belcrest Road, #150 Hyattsville, Maryland

29d. Date signed (Month, Day, Year)

March 22, 2012

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

MAR 26 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 9:15 Grace Alice Rosner March Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Rockville Montgomery Arbor Place Assisted Living Year If Under 24 Hrs. 7. Age (In yrs. last birthday If Under 1 8 Date of Birth Birthplace (State or Foreign Country) Social Security Number **Funeral** Days Hours Min **Director** 364-22-1506 1 □ M 2**X** F Usual Residence of Decede 87 Mar 23, 1924 Michigan 28a-f show äţ 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 1 Yes 2 No Rockville Maryland Montgomery ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be n 4413 Muncaster Mill Rd 20853 USA items 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 ANo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. ò þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify Specify: White "natural" Completed 3 X Widowed 4 □ Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Community Organizer Jewish Causes Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fishers is marked o မ Fay Levine Henry Willner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 sl it of Health a If item 27 is 3620 Raymond St, Chevy Chase, MD 20815 Marjorie Rosner/Daughter Department of Heah Important: If its any injure Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 X Removal from 4 ☐ Donation 5 ☐ Other (Specify)
Signat le if Fu dral e ic ___nsee Eternal Light Mem Grdns Mar 14, 2012 Boynton Beach, FL 21. Signat e 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave, Silver Spring, MD 20904 23a. Part 1. El ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death 4 days shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Multi-system organ failure disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) and and Exami Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): buria Physician/Medical Division of Vital Records, P.O. Box 68760 phys. IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death 2 X No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autonsy 2 No Yes 2 X No 1 🗌 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 🛚 No Other: 1 Yes မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) Assisted 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Living iniury work? 1 Yes 2 No 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State, Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check 29b. Signature nd title of ce 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 06-2011

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Henjum,

MD

32. Registrar's S

Philip G.

31. Date filed (Month, Day, Year)

MAR 1 4 2012

D0035045

18109 Prince Philip Dr, #200, Olney, MD 20832

March 12, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State	State of Mary				Mental Hy	giene			
		_	Registra AMEND#19aperINF, 1. Decedent's Name (First, Middle, Last)	3/26/12 ; BMW,1	vbCa Cer	tificate of L	Death		Reg. No. 2	2 10 16 1		
	Physicia	n/						Date of De Month	1 ^{Day} 201	3. Time of Death		
1	Medic Examin		Josefina Rodriguez 4a. Facility Name (if not institution, give stre	eet and number)		4h City Town or	Location of Death	March	4c. County of De			
	LAGIIIII	GI	Holy Cross Hospita	,		Silver				gomery		
	Funeral		5. Social Security Number 6. Sex	7. Age (In	yrs. last birthday)		If Under 24 Hrs. Hours Min.	8. Date of Bir	th g. I	Birthplace (State or Foreign		
	Director			M 2 🗓 F	75 Yrs.	Worth's Days	Tiours Will.	(Month, Da	Day, Year) Country) 31 1937 Colombia			
	nd how at	'n	Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or Loc	ation	<u> </u>	Jan.	71 1737	10d. Inside City Limits		
	faryla 3a-f s tified	ecto	MD Montgome	rv	Rockvi	i11e				1 ☐ Yes 2 🗓 No		
	the h	ΙĐΙ	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?		
	s 23a nust b	Funeral Director	207 Cork Tree Lane			2085	50		United	United States		
980	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Health and Mental Hygiene. The marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	11. Marital Status 12 1 Never Married 2 Married 3 Widowed 4 Divorced	. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.	If	Yes, specify Cuba	ispanic Origin? (Spin, Mexican, Puerto Specify: Col	Rican, etc.)	Black, W	merican Indian, hite, etc. √hite		
Maryland 21215-0036	/ithin 72 hou iene. r than "natu the Medical	Completed	15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4 or 5+)	(Give k	ent's Usual Occup ind of work done o NOT use retired) litor	ation during most of work	ing	16b. Kind of Busines			
פַ	iled w Il Hyg othe	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam	ne (First, Middle,	Maiden Surname)			
/lar	d be f Menta arked aric ev	일	Jose Tamayo		Luisa	Acevedo						
lar.	shoul and l	1	10 Informant's Name/Relationship (Type,	Print)	1	-			er, City or Town, State,			
e)	and 2 Health	7	- Eliana Elegre/Daug 20a. Method of Disposition				-		e, MD 2085			
			1 ☐ Burial 2 🗶 Cremation 3 ☐ Re	moval from State		atory or other plac	e)	Date	20c. Location - City			
≣	permit. Page Department of Important: If any injury or once.		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lightsee		Metropoli	Name and Addres		9, 2012	Alexandri neral Home			
ñ	Dep Imp	-	What &	Nell			. Б			, MD 20877		
	hysician/		23 . Part 1. En er the disease, or complice shock, o neart failure. List only one of mmediate cause (Final	cause on each line.	death. Do not ente	r the mode of dyin				Approximate Interval Between Onset and Death		
1	Medical Examiner		isease condition resulting in death)	Respirato Due to (or as a co	nsequence of):	Le						
		Je.	Sequentially list conditions, b.	End Stage		itial Lur	ng Diseas	e				
	D 1sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a con	isaquence oi).							
	xecut	Еха	that initiated events c. resulting in death) Last	Due to (or as a cor	nsequence of):					+		
09	icate be executed physician and the burial-transit	edical	L _{d.}									
9/8	tificate ng ph) as th	Med	IF FEMALE:									
Box 68	law requires that the death certificate be executed has been signed by the attending physician and e.2 should be detached for use as the burial; trans.	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	i. If yes, outcome of pi 1 ☐ Live Birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death 3	Ectopic pregnand Other (specify)	у		23d. Date of Month	delivery Day Year		
P.O.	at the d by t detacl		Part II. Other significant conditions contr	ibuting to death but no	ot resulting in the ur	nderlying cause giv	ven in Part I.	23e. Did t	obacco use contribute	to the cause of death?		
S, T	signe d be	d by				, , ,				Probably 4 X Unknown		
ord Ord	been	Completed						24a. Was	an 24b. Were	autopsy findings available		
ě	The law ate has page 2	omp						auto perfo 1 \square Yes	psv prior	to completion of cause of ?		
Vital Records,	sician: The law is certificate has t	o l	25. Was case referred to medical			26. PI	ace of Death (Chec		2 △ No1 1 □	Yes 2 No		
Ĭ	nysici nis cer I direc	To B	examiner? 1 Yes 2 No	spital: 1X Inpatient	2 ER/Outpatien	t 3 🗆 DOA Othe	er: 4 Nursing He	ome 5 🗆 Resid	dence 6 Other (Sp	pecify)		
Division of	ending Pt sath. or: After th	Certificate:	27. Manner of Death 1 A Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Ye.	ar) 28b. Time of injury	28c. Injun work M 1 🗆		28d. Describe h	now injury occurred			
DIVISI	To the Pospital or Attending Physician: Within 24 hours after death Within 24 hours after death Within 24 hours birector. After this certification of the Funeral director, it is a completely filled in by the funeral director, it is a completely filled in by the funeral director.		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - building, etc. (Sp	pecify)			City or Tov		,		
	he Hosp in 24 hou he Funer pletely fil	Medical	29a. Certifier (Check 2 Medical Examiner only one) 3 Certifying Nurse F	 On the basis of exami 	nation and/or investi	gation, in my opinio	on, death occurred a	t the time, date a	and place, and due to the	ne cause(s) and manner stated.		
	Series 2		29b. Signature and title of certifier	2 ~	ND	29c. License	e number > 639	-	19d. Date signed (Month, Day, Year)			
			30. Name and address of person who com			*						
			Pothu Raju Nagabhy			en Road,	Silver S	pring,	MD 20910			
	Stat Registra		31. Date filed (Month, Day, Year) MAR 2 0 2012	62. Registrar's S	Signature Sec.	1.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Physician/ Medical **Examiner** 8. Date of Birth (Month, Day, Year) If Under 24 Hrs. **Funeral** ge (In yrs. last birthday) Days Hours Min. Months 579-14-7495 **Director** 1 □ M 2 🛂 F 89 June 1, 1922 Washington, DC show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10c. City, Town or Location at 10a, State 10d. Inside City Limits Director or 28a-f sh notified a 1 🗌 Yes 2 🔀 No MD Montgomery 01ney 10e, Street and Numbe 10f, Zip Code r items 23a or iner must be n 10g. Citizen of What Country? Funeral 17027 Moss Side Lane 20832 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Hygiene. other than "natural", or iter rent, the Medical Examiner 11. Marital Status 14. Race - American Indian, Armed Forces? þ 1 Never Married 2 Married Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2 ANo Specify. Specify: Completed 3 Widowed 4 XXDivorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Practical Nurse Health Care Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Carl Stephen Conrad Cecelia Ellen Connolly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosemary Rucchio/Daughter 17027 Moss Side Lane, Olney, MD 20832 Baltimore, 20a. Method of Disposition 20b Place of Disposition (Name of 20c. Location - City or Town, State March 19 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Arlington, VA Columbia Gardens Cemetery 2012 Francis J. Collins Funeral Home 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner B that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last the attending physician Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Was dece-in the past 12 mg 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Pregnant at time of death Unknown g Unknowi signed by to death by not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by or Attending Physician; The law requires 1 Yes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ours after death.

eral Director; After this certificate has I filled in by the funeral director, page 2 s autopsy 1 ☐ Yes 2 ☐ No Yes Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No Other: 1 Yes Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 🗌 Yes 2 🗌 No M Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined City or Town, State) within 24 hours a To the Funeral L To the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Sempletely fi 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature a

State Registrar 31. Date filed (Month, Day, Year)

(Item 23a) (

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2072 4:05 am Maxine Cecelia Rotter Physician/ March Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Montgomery Rockville Potomac Valley Nursing Home Birthplace (State or Foreign Country) Year If Under 24 Hrs If Under 1 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** 579-40-1139 1 🗆 M 2 🕱 F **Director** 84 02/16/1928 New York Usual Residence of Decedent 10d. Inside City Limits "natural", or items 23a or 28a-f show sdical Examiner must be notified at 10c. City, Town or Location should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f shov 10a. State 10b. County Director 1 🗌 Yes 2 🗓 No Adelphi Prince George's Maryland 10f. Zip Code 10g. Citizen of What Country? Funeral u.s.A. 9203 Muskogee Place 20783 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No 11. Marital Status Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates Specify White 3 Widowed 4 Divorced Completed event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Weight Loss Lecturer Be 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) 2 Jeanette Arenson permit. Page 1 and 2 should be Department of Health and Ments Important: If item 27 is marked any injury or extra Abraham Bortnick 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9203 Muskogee Place, Adelphi, Maryland 20783 Leonard Rotter - Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 🗓 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify)
Sign up of Filleral Jervice Acense Judean Memorial Grdns 03/13/2012 Olney, Maryland 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Dementia disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate course. Enter Underlyin Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and the attending physician and the for use as the burial transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant Year signed by the atte in the past 12 months?
1 Yes 2 X No Month Day 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Tes 2 X No 3 Probably 4 Unknown Myelodysplastic Syndrome 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 1 🗌 Yes 2 🗎 No 1 ☐ Yes 2 🗓 No 26. Place of Death (Check only one) the funeral director. Be 25 Was case referred to medical examiner? 2 🛚 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: work? 1 ☐ Yes 2 ☐ No 5 Pending 1 X Natural M Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completely filled in by City or Town, State Medical 1 🖔 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 🗌 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 🗀 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one 29d. Date signed (Month, Day, Year) and title of certifier 29c. License number 29b. Signature March 15, 2012 D38262 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9043 Shady Grove Court, Gaithersburg, Maryland 20877 Anurita Mendhiratta, M.D., 31. Date filed (Month, Day, Year) State MAR 16 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year obinson 8:02 PM MargareT 2012 Medical 4a. Facility Name (Knot institution, give street and number, **Examiner** 4b. City. Town, or Location of Death 4c. County of Death linton George If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min. Director 1 🗆 M 2 🗶 Usual Residence of Decedent 26 irginia 28a-f show filed within 72 hours after death with the Maryland notified at 10a. State 10b. County 10c. City, Town or Location 0d. Inside City Limits Director 1 Yes 2 No (on ò 10e. Street and Number 10g. Citizen of What Country? must be n Funeral ,5, 07 items? 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, the Medical Examiner Black, White, etc ō by 1 Never Married 2 Married 2 No ☐ Yes Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. "natural", 3 ₩Widowed 4 □ Divorced Completed ack 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Homema 4.+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Department of Health and Ment Important; If item 27 is marke any injury or other traumatic John Molmes Page 1 and 2 should I ment of Health and Mc 19a. Informant's Name/Relationship (Type, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20745Robinson Perton Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3-16-2012 King George 21. Signature of Funeral Service Lice 2294012 Washington 22. ame and Address of Facility MØ1325 phic 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of that the death certificate be executed the burial-tran the attending physician and Due to (or resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months Pregnant at time of death be detached Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ or Attending Physician; The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed . Were autopsy findings available prior to completion of cause of death? 24a. Was an after death.

Director: After this certificate has page 2 autopsy 1 Yes 2 No 2 - No Yes filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: Certificate: To 1 Inpatient 2 PER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 \square Pending injury Natural work? 1 🔲 Yes 2 No Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a To the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signature and title of 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

5

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Ruth Smigielski 2012 March 3:20 P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Harford 487 Winterberry Drive Edgewood 8. Date of Birth (Month, Day, Year) Dec. 21,1931 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 🗆 M 2 🗶 F 80 Months 218-28-4561 Maryland Yrs Director Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director MD Harford Edgewood 1 Tes 2 X No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 487 Winterberry Drive 21040 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married ☐ Yes 2X No Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify. 3 ₩ Widowed 4 Divorced "natural" Completed Specify. Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry المالية. خوا Hygiene. حمد than "r (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) the 12 should be filed with alth and Mental Hygien 27 is marked other the traumatic event, the Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Arthur Reinholdt Marie Nauman 19a. Informant's Name/Relationship (Type, Print) Daughter-19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Heatth ar Important: If item 27 is any injury or other trau Debbie Smigielski / in-law 487 Winterberry Drive Edgewood, MD 21040 Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🕅 Burial 2 🗌 Cremation 3 🗎 Removal from State Meadowridge Memorial Park March 15, Elkridge, MD 4 ☐ Donation 5 ☐ Other (Specify) 2012 21. Signature of Funeral Service Licensee Barranco & Sons, P.A. Severna Park Funeral Home 495 Ritchie Hwy. Severna Park, 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 10-1 Physician/ disease or condition resulting in death) Medical (or as a consequence of) Examiner Proforaction MYOCARDIAL Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of Exami death certificate be executed the burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Box 68760 as t IF FEMALE: USe 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months2 Day Pregnant at time of death 2 - 100 9 Unknown a 🗆 Unknown that the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2 No Yes 1 Yes 25. Was case referred to medical Division of Vital funeral director. Be 26. Place of Death (Check only one) Hospital 2 INO ပ 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1-Natural work? injury 5 Pending s after death. Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 12 # D55306 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BASO H. COLE HD 9106 (HLADEUH 200 31. Date filed (Month, Day, Year) State MAR 1 4 2012

DHMH 17 Rev 7/2009

Registrar

		-		artment of Health and Menta		2 10166								
	Physicia	n/	Decedent's Name (First, Middle, Last) Emily Spire Steinberg	Mor	e of Death	3. Time of Death								
È	Medic Examin	al er	4a. Facility Name (if not institution, give street and number) Assisted Living Well Compassionate Care	4b. City, Town, or Location of Death Millersville	ch 11, 2012 4c. County of Dec Anne Ara	ath								
	Funeral Director		5. Social Security Number 6. Sex 1. Age (In yrs. last birthday) 6. Sex 1. □ M 2 🗶 F 88 1. Sex 1. Age (In yrs. last birthday)	Months Days Hours Min. (Mon	9. B of Birth hth, Day, Year) C 01,1924 Of	Birthplace (State or Foreign Country) District Columbia								
	yland -f show ed at	ctor	Usual Residence of Decedent 10a. State 10b. County Anne Arundel Sever	<u> </u>		10d. Inside City Limits								
	the Mar a or 28a- be notifi	Funeral Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What C	1 ☐ Yes 2 💢 No								
	ath with ems 23a r must	unera	55 Marnel Drive 11. Marital Status 12. Was Decedent Ever in U.S. 13.	21146 Was Decedent of Hispanic Origin? (Specify Yes		USA 14. Race - American Indian,								
Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	2	1 Never Married 2 Married 1 Voc 2 Vivia	Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, e 1 ☐ Yes 2 ☒No Specify:	Black, White, etc. Specify: White									
215-(n 72 hoi e. an "nat Medica	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of working OO NOT use retired)	16b. Kind of Busines:	Kind of Business/Industry								
d 21	ed withi Hygiene sther th e nt, the	Be Co	17. Father's Name (First, Middle, Last)	Home Middle, Maiden Surname)										
ylan	d be file Mental arked c	일	William Burton Spire	Lawton										
Man	2 shoul Ith and I 27 is ma		19a. Informant's Name/Relationship (Type, Print) Carol Swain / Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 55 Marnel Drive Severna Park, MD 21146 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) 4 Donation 5 Other (Specify) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 55 Marnel Drive Severna Park, MD 21146 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Baltimore, MD											
Baltimore,	Page 1 and lent of Hea int: If item ry or othei													
Balti	permit. Pepartm Departm Importa any inju		21. Signature of Funeral Service Licensee	3 Name and Address of Soults P.A.		Funeral Home								
240	Physician/ Medical		23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition) The CVA Approximate Interval Betwoen the cause (Final disease or condition)											
	Examiner		resulting in death) Due to (or as a consequence of): Failure to thrive			6 months								
	outed nd transit	caf Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events											
90	te be executed nysician and he burial-transit		resulting in death) Last Due to (or as a consequence of): d.											
. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate is within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ 4 ☐ Pregnant at time of death 5 ☐ 9 ☐ Unknown	☐ Ectopic pregnancy ☐ Other (specify)	23d. Date of d Month	lelivery Day Year								
s, P.O.	requires that the des been signed by the s should be detached	d by Pr	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 23e	e. Did tobacco use contribute to									
Records,	e law requi	24a. Was an autopsy performed? de												
tal R	cian: Th	25. Was case referred to medical 26. Place of Death (Check only one)												
of Vi	y Physic er this co	유	1 ☐ Yes 2 🕱 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie 27. Manner of Death 28a. Date of injury 28b. Time o	Residence 6 Other (Spe	ecify (15515Kd Iving									
Division of Vital	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical Certificate:	1 X Natural 5 ☐ Pending (Month, Day, Year) injury 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, st	M	ation (Street and Number or R	hural Pay to Number								
Divi	oital or A urs after ral Dire	al Cer	building, etc. (Specify)	City	or Town, State)									
	the Hosp in 24 ho the Fune		29a. Certifier (Check 2 ☐ Medical Examiner: On the best of my knowledge, death only one) (Certifying Nurse Practitioner: To the best of my knowledge, death only one)	stigation, in my opinion, death occurred at the time	, date and place, and due to the	e cause(s) and manner stated.								
		29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 23 12 12												
	#1x?		30. Name and address of person who completed cause of death (Item 23a) (Type, Lois Janc Schramik CRNP J.13 N.1	Print) Or Severna Par	k MD 21146									
	Stat Registra	e ir	31. Date filed (Month, Day, Year) MAR 1 4 2012 32. Fegistrar's Signature	hall										

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760,

		Por it in the last it is	epartment of Health and N								
		1 - Registrar / 16/2012 AACO HEALTH DEPT. CMH 1. Decedent's Name (First, Middle, Last)	Certificate of Death	2. Date of Dea	th 3. Time of Death						
Physicia /Medic	_	Geraldine C. Slipka		Month	Day Year 7 12						
Examine		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death						
		FutureCare Chesapeake	Arnold day) If Under 1 Year If Under 24 Hrs.	O Data of Disth	Anne Arundel						
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	Months Days Hours Min	8. Date of Birth (Month, Day	(, Year) Country)						
	ļ	212-30-7512 Usual Residence of Decedent		May 26,							
72 hours after death with the Maryland ratural", or Items 23a or 28a-f show dicel Execution must be notified at	ō	10a. State 10b. County 10c. City, Town of the county 1			10d. Inside City Limits 1 ☐ Yes 2X No						
n the f	Director	10e. Street and Number	10f. Zip Code	1	10g. Citizen of What Country?						
23a c	la	305 College Parkway	21012		USA						
tems	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	 Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerte 	pecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.						
urs afte	þ	1 ☑ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 ☐Yes 2X No Specify:		Specify: White						
72 hou	eted	15. Decedent's Education 16a, D	Decedent's Usual Occupation Give kind of work done during most of work	rina	16b. Kind of Business/Industry						
within and.	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	ife. DO NOT use retired) enographer	Civil Service Federal Government							
filed v Hygie other t		12 17. Father's Name (First, Middle, Last)		ne (First, Middle,	Maiden Surname)						
uld be Mental Irked c	To Be	Edward Slipka	Cristi	ne Katal	lik						
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Medical Example of must be notified at once.			Mailing Address (Street and Number or Ru 36 Little Magothy V								
es 1 al of Hea fitem	Ì	20a. Method of Disposition 20b. Place of L	Disposition (Name of crematory or other place)	h 13,	20c. Location - City or Town, State						
it. Pag rtment rtant: I njury o			Cemetery	012	Baltimore, MD						
Depa Impo any it		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Barranco & Sons, F 495 Ritchie Hwy,	A. Seve	erna Park Funeral Home erna Park, MD 21146						
		23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart tailure. List only one cause on each line.		or respiratory ar	rest, Approximate Interval Between Onset and Death						
Physician		Immediate Cause (Final disease or condition resulting in death)	ntia		Onset and Death						
/Medical Examiner		Due to (or as a consequence of):								
P ±	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying):								
te be executed ysician and e burial-transit	Examiner	use (Disease or injury to initiated events c									
re be exprician	calE	bue to (of as a consequence of	<i>,</i>								
tificate ig phy as the	ledic	d									
leath certificate eather attending physi	an/N	IF FEMALE: 23b. Was decedent pregnant in the part 12 months? 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death	3 ☐ Ectopic pregnancy		23d. Date of delivery						
The law requires that the death certificatate has been signed by the attending phoage 2 should be detached for use as the	Physician/Medi	in the past 12 months? 1 Yes 2 No 4 Pregnant at time of death 9 Unknown 9 Unknown	5 Other (specify)		Month Day Year						
s that t	by Ph	Part II. Other significant conditions contributing to death but not resulting in	he underlying cause given in Part I.	23e. Did to	obacco use contribute to the cause of death?						
w requires that the dispension of the should be detached		failure to thrive		1 □ Y	res 2 No 3 Probably 4 Unknown						
e law r has be	Completed	/		24a. Was autop	prior to completion of cause of						
sician: The certificate hirector, page				1 □Yes	rmed? death? 2 No 1 Yes 2 No						
s certilirecto	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Out	0.41	th (Check only of	ne) dence 6 □Other (Specify)						
ig Phy ig Phy ier this	\vdash	27. Manner of Death 28a. Date of Injury 28b. Ti		F	now injury occurred						
eath. or: Af	atio	2 Accident investigation	M 1 ☐ Yes 2 ☐ No								
or Att after d Direct in by	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farr building, etc. (Specify)	n, street, factory, office	28f. Location (S City or Tow	Street and Number or Rural Route Number, vn, State)						
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, p		29a. Certifier (Check only (Ch	death occurred at the time, date and place	e, and due to the	cause(s) and manner as stated.						
the H thin 24 the Fi	Medical	one) and manner stated.									
5 ½ 6 ⊠		29b. Signature and title of certifier	29c. License number		29d. Date signed (Month, Day, Year) Narch 09, 2012						
2170		30. Name and address of person who completed cause of death (Item 23a) (1	ype, Print)								
, ,		MOhit Wegi 8601 Veteran. 31. Date filed (Month, Day, Year) 32, Registrar's Signature	s May, Miyersi	rille,	MD 21108						
Sta Registra		31. Date filed (Month, Day, Year) MAR 1 4 2012 MAR 1 4 2012 MAR 1 4 2012	back								
		Como p. y									

ORIGINAL

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		AMEND#10E per FH S State 3/20/2012 AACO HEAL Registrar	tate of Marylan	d / Depa <i>Cen</i>	rtment tificate	of Health of Death	n and N	Mental Hyو :	giene Reg. No. /	2012	10168
Physicia		1. Decedent's Name (First, Middle, Last) Crorse Allen	Shegogue					2. Date of Dea Month March 1	th Day	12 Year	3. Time of Death 5:29 A M
Medic Examin		4a. Facility Name (if not institution, give stree 45755 Stoney Run Dr	· ·			wn, or Locatio	on of Death	naten 1	4c. Cc	ounty of Death Mary 's	13.23 A
Funeral Director	ı	5. Social Security Number 216-60-3747 Usual Residence of Decedent 10a. State 10b. County 6. Sex 1 □XM	2 G F 7. Age (In yrs. la	Yrs. Young Town or Loc		Year If Und Days Hours	ler 24 Hrs. Min.	8. Date of Birtl (Month, Day October	Year)	g. Birthp Coun 953 Ma	olace (State or Foreign try) ryland Od. Inside City Limits
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	Maryland Prince Geo 10e. Street and Number 30 Orchard Towne Co	rge's Lau	rel	10f. Zip 0				10g. Citizei	n of What Cour	1 X Yes 2 □ No
urs after death :ural", or items al Examiner mu	þ	11. Marital Status 1 Never Married 2 Married 2 Midward 4 Notation	Mas Decedent Ever in U.S. Armed Forcas? I Yes 2A No f Yes, Give Year or Dates.	5. 13. W	as Deceder Yes, specify		can, Puerto	ecify Yes or No- Rican, etc.)	14.	Race - Americ Black, White, e	etc.
ed within 72 ho Hygiene. other than "nai ott, the Medica	To	15. Decedent's Educat (Specify only highest grade co Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last)		Ìife. DC	ind of work NOT use re	done during m etired) OCESSO	r	ing ne (First, Middle, i	Finai		dustry
ould be file d Mental I marked o matic eve		George Steven Shegog		I 481 34 33		Dor	othy	Lambert	Fay		
f and 2 sho f Health an item 27 is other trau		Linda Carol Balach/ 20a. Method of Disposition	Sister 20b. P	1983!	5 Fall	Court	Grea	t Mills Date	, MD		
permit. Page 1 and 2 s Department of Health Important: If item 27 any injury or other tr		1 ☐ Burial 2 ☐ Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	ovar nom state	emetery, crem ntt_Cre	emator			/2012		orf, MD	
permi Depar Impol any ir		23a. Part 1. Enter the disease, or complicati		16	6000 <i>F</i>	nnapo 1	is Ro	bert E. ad Bowi or respiratory arr	e, MD	20715	Approximate
Physician/ Medical Examiner	,	shock, or heart failure. List only one call mmediate Cause (Final disease or condition resulting in death) Sequentially list conditions, b. —	Lung Cance Due to (or as a consequ		ge IV					8	Interval Between Onset and Death Months
be e sicial buri	edical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):									
To the Hospital or Attending Physician: The law requires that the death certificate k within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Med	in the past 12 months?	f ves, outcome of pregnal 	I death 3 🗌	Ectopic pre Other (spec				230	d. Date of delive	ery Day Year
requires that the der been signed by the s should be detached	ed by P	Part II. Other significant conditions contrib Anemia, Emphysema,	uting to death but not res	ulting in the ur	nderlying ca	use given in Pa	art I.	,,			ne cause of death?
sician: The law req s certificate has bee lirector, page 2 sho	Completed by	Peripheral Vascular	Disease					24a. Was a autop perfor	sy med?	24b. Were autoprior to codeath?	osy findings available mpletion of cause of
Physician: 1 this certifice eral director, p	To Be	25. Was case referred to medical examiner? 1 Yes 2 X No	ital:	ER/Outpatient	3 🗆 DOA	26. Place of D		k only one) ome 5 ☐ Resid	ence 6 X	Other (Specify)
ending Ph eath. or: After th the funeral	Certificate:	1 Natural 5 ☐ Pending 2 ☐ Accident Investigation	8a. Date of injury (Month, Day, Year)	28b. Time of injury		Injury at work?		28d. Describe h			
To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer		4 Homicide determined	office		28f. Location (S City or Tow	n, State)					
thin 24 ho thin 24 ho the Fune impletely f	Medical	29a. Certifier 1 X Certifying Physician (Check 2 Medical Examiner: 6 only one) 3 Certifying Nurse Pra 29b. Signature and title of certifier	On the basis of examination	and/or investi	gation, in my death occurr	opinion, death red at the time,	occurred a date and pl	t the time, date a ace, and due to tl	nd place, an ne cause(s) a	nd due to the car and manner as s	use(s) and manner stated. stated.
Mi Mi CO		Don X. M.	mlil		D30	icense numbe)573	:1		29d. Date s	igned (Month, i	Jay, Year)
H		30. Name and Adress of person who compl Jon K. Minford, M.D	. 10710 Cha	rter D		<u>Columb</u> i	a, MD	21044			
Stat Registra	te	31. Date filed (Month, Day, Year) MAR 14 2012	32. Fegistrar's Signat	ure	arke						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 03 Month Physician/ Day Jean Schneider 12 2012 2341 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 4408 Tranquil Trail Hurlock Dorchester 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Min. Months Hours Director 216-60-5474 1 □ M 2 🔽 F 59 07/12/1952 Severn, MD 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Dorchester Hurlock 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4408 Tranquil Trail 21643 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married 1 Yes If Yes, Give 2**X** No 1 ☐ Yes 2 No Specify: Completed 3 Divorced 4 Divorced White Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry

School Bus Driver

Smith Bus Company

18. Mother's Name (First, Middle, Maiden Surname)

Ladner

22 South Green St. Baltimore, MD 21201-1595

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Ethe1

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any hjury or other traumatic event, the Medical Examiner must be notified at once. Baltimore, Maryland 21215-0036

Be

ပ

(Specify only highest grade completed)

College (1-4 or 5+)

Elementary/Secondary (0-12)

17. Father's Name (First, Middle, Last)

Joseph Foster

19a. Informant's Name/Relationship (Type, Print)

Ph_sician/ Medical **Examiner**

> Medical Certificate: To Be Completed by Physician/Medical Examiner attending physician and for use as the burial-tran been signed by the a should be detached t within 24 hours after deam.
>
> To the Funeral Director. After this certificate has been signompletely filled in by the funeral director, page 2 should I

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

Carl Schneider Jr	• Spouse	4	4408 Tranquil Trail Hurlock, MD 21643						
20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	20b. Place of cemeter, Atlant:	, crematory o	r other place)	i	Date 20c. Location - C		,	
21. Signature of Funeral Service License	MI			and Address of Fac sty Fune	- ,	ome P.A	. 85 Ga	l Annap mbrills	olis Road MD 21054
23a. Part 1. Enter the disease, or complishock, or heart failure. List only one Immediate Cause (Final disease or condition		the death. Do no	ot enter the m	ode of dying, such	as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
resulting in death)	Due to (or as a	consequence o	f):	,					1200
Sequentially list conditions, if any bedieved to the cause. Enter Underlying Cause (Disease or injury	Due to or as a	cons quence o	fir:						
that initiated events resulting in death) Last	Due to (or as a	consequence o	f):						
in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions cor	1 ☐ Live Birth 2 4 ☐ Pregnant at 9 ☐ Unknown	time of death	5 Gther		art I.	23e, Did 1			Day Year to the cause of death? Probably 4 🗆 Unknow
						24a. Was auto perfe 1 \square Yes	psy ormed?	prior to death?	sutopsy findings available completion of cause of \square No
25. Was case referred to medical examiner?				26. Place of D	eath (Chec	k only one)	177		
1 ☐ Yes 2 No	ospital: 1 🗌 Inpatier	nt 2 🗆 ER/Out	patient 3 🗌	DOA Other: 4	Nursing Ho	ome 5 Sesi	dence (3 ☐ Other (Spe	ecify)
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	28a. Date of injury (Month, Day,	Year) 28b. Ti	me of jury M	28c. Injury at work? 1 Yes 2		28d. Describe	how injur	y occurred	
3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injur- building, etc.		ory, office		28f. Location (Street and Number or Rural Route Number, City or Town, State)			ural Route Number,	
only one) 3 🗌 Certifying Nurse	er: On the basis of exa	amination and/or	investigation,	in my opinion, death	occurred a	t the time, date	and place	e, and due to the	e cause(s) and manner sta
29b. Signature and title of certifier			2	9c. License numbe			29d. Da	te signed (Mon	th, Day, Year)
1////				D862	506	7	150	1-03 /	4 2014

DHMH 17 Rev 06-2011

State Registrar 30. Name and agoress of person who completed cause of death (Item 23a) (Type, Print)

Martin Edelman Greenbaum Cancer Ctr.

31. Date filed (Month, Day, Year)
MAR 15

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ March 13^{Day} 2012^{ear} 10:54 A_M Cleone Marie Smith-Dade Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
Anne Arundel Examiner Churchton 1215 Fairfax Avenue 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 579-14-3232 1 □ M 2 🛣 F **Director** 07/18/1921 New Jersey 90 Yrs. Usual Residence of Deceden 28a-f shov 10a. State notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Anne Arundel Churchton 10e Street and Number ō 10f. Zip Code 10g. Citizen of What Country? iral", or items 23a or Examiner must be Funeral 20733 United States 1215 Fairfax Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. by 1 Never Married 2 Married 1 Yes 2 No Specify: Yes 2 No Maryland 21215-0036 If Yes, Give Year or Dates White "natural", Specify: 3 Widowed 4 Divorced Completed Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) 72 (Give kind of work done during most of working Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) other traumatic event, the Education Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked o Frank Joseph Pelka Juanita Harbor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 short of Health a 5546 Carvel Street, Churchton, Maryland 20733 Lisa Bates/Daughter Baltimore, 20a. Method of Disposition 20h Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o cemetery, crematory or other place, 1 🗓 Burial 2 🗆 Cremation 3 🗆 Removal from State Brentwood, Maryland 4 Donation 5 Othe (Specify) Lincoln Cemetery 3-16-2012 21. Signature of Pineral So 22. Name and Address of Facility George P. Kalas Funeral Home <u> 2973 Solomons Island Road, Edgewater, MD 21037</u> 23a. Pard 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween nset and Death Immediate Cause (Final Ph_sician/ Tracture disease or condition resulting in death) MONTH Medical Due to or as a consequence of) **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to lor as a consequence of): 1 Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed and I-tran that initiated events Due to (or as a consequence of) resulting in death) Last burial physician s the buria Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year the 9 Unknown 9 Unknown signed by the Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page perform certificate 2 🗌 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 No in 24 hours arter de de florector: After this committeely filled in by the funeral dis 4 Nursing Home 5 Residence 6 Other (Specify) မြ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide iniury 5 Pending UNTM 2/2011 1 ☐ Yes 2 🗷 No 12114 Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined tome Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 24 hou To the Funer completely fil 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) puty 29b. Signature and title of certifier 29d. Date sigged (Month, Day, Year) 14 0605 10 Name and add se of death (Item 23a) (Type, Print)

State Registrar MID

29

Registrar's Signati

ON

້ 5 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ 3115 AM Diane Marie Statler 201 Mari Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 16010 Cloverton Lane Williamsport Washington If Under 1 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Year If Under 24 Hrs **Funeral** Hours Min 217-28-5209 1 🗆 M 2 🔀 F Director 79 Yrs July 31,1932 Maryland Usual Residence of Decede 28a-f show the Maryland notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Washington Williamsport ò 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r with Funeral 16010 Cloverton Lane 21795 USA items 2 death 1 Was Deceus Armed Forces? Vas 2 XXNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, ı "natural", or iten edical Examiner r Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 hours after 1 Yes 2XXNo Specify. Specify. 3 Midowed 4 ☐ Divorced Completed White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working within 72 Il Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Accounts Payable Clerk Truck Manufacturer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fisherships is marked of John Howell Hetzer Mary Catherine Swope permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10709 Timothy Drive Williamsport, Maryland 21795 Cindy S. Everly-Daughter 20a. Method of Disposition 20h. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation from State 4 Dopation 5 D Othe Greenlawn Mem. Park March 21,2012 Williamsport, Maryland 21. Sign ure of F Osborned Funeral Home, P.A. 425 S. Conococheague St.Williamsport,MD 21795 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Ø Medical resulting in death) Due to (or s a onse uence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Pregnant at time of death ed by the a Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 1 Tyes Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page performed certificate 2 🗌 No Yes I ☐ Yes Was case referred to medica. Be 26. Place of Death (Check only one) Hospital 2XXNo မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home Residence 6 D Other (Specify) After this 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural iniury 5 Pending ours after death.

eral Director: Afte filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2 To the I Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one

State Registrar 31. Date filed (Mor

gistrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month. Dav. Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ 2012 10:35 ам Melvin Henry SHANK March Medical 4a. Facility Name (if not institution, give street and number) c. County of Death Washington **Examiner** 4b. City, Town, or Location of Death 17407 Lappans Road Fair Play Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Davs Aug. 16, Year) 1923 1x M 2 - F 220-16-3034 88 **Director** Pennsylvania Usual Residence of Decedent items 23a or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Washington Maryland Fair Play 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21744 U.S.A. 17407 Lappans Road 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married Yes Yes Yes, Give 2 X No Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after white 1 Yes 2 No Specify: Specify: "natural", Completed 3 Divorced Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) other than Elementary/Seconday (0-12) College (1-4 or 5+) soft drink distributor Inventory Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental F Important: If item 27 is marked o any injury or other traumatic eve Harvey K. Shank Rose L. Dennis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Shank - daughter 2105 Rose Theatre Circle, Olney, Maryland 20832 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Greenlawn Memorial 1 Burial 2 Cremation 3 Removal from State March 2019 4 ☐ Donation 5 ☐ Other (Specify) Williamsport, Maryland 21. Signature of Funeral Service Lice 22. Name and Address of Facility Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Medical resulting in death) Examiner Securities and the securities of any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending p for use as 1 IF FEMALE 23b. Was decedent pregnant 23d Date of delivery in the past 12 months? Day Yes 2 No 1 ☐ res ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 No Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🕊 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying these Pranticions T. In cost of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 To the I 29b. Signature and title of opleted cause of death (Item 23a) (Type

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ March 16, Beverly Anne SHANHOLTZ 2012^e 6:42 а. м Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington 536 George Street Hagerstown Social Security Numbe If Under 1 Year I If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 □ M 2X F April 1,1941 212-38-9234 70 **Director** Maryland Usual Residence of Decedent 28a-f show 10a State r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Directo Maryland Washington 536 George Street 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 536 George Street 21740 USA permit. Page 1 and 2 should be filed within 72 hours after death V Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Tes 2 No Specify: white Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) garment industry seamstress Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Roy Hayes Parlett Ethel Mae Myers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Robert Shanholtz, husband 536 George Street, Hagerstown, Maryland 21740 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Rose Hill Cemetery 3/21/2012 4 Donation 5 Other (Specify) Hagerstown, Maryland 21. Sign are of Funeral Service 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease of injury that initiated events resulting in death) Last -tran and Due to (or as a consequence of): attending physician for use as the burla Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Day Year Pregnant at time of death 1 Yes 2 No g Unknown Division of Vital Records, P.O. signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 □ No 3 □ Probably 4 □ Unknown Completed After this certificate has been si funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manper of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director; Af completed filled in by the fu 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print) meck State Registrar

Please Type or Print in Black Indelible Inko 3 Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Year **Physician** DANA 1050 A M SIMONSEN BRIAN MARCH 2012 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Johns Hopkins Bayview Medical Center **Baltimore** | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | June 1, 1986 9. Birthplace (State or Foreign Country) Washington, DC 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** XXM 2□F 25 215-27-3713 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2X No Director Virginia Fairfax Centreville 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 6009 Netherton Street 20120 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 \(\overline{\text{Type}} \) Yes 2 \(\overline{\text{No}} \) If \(\overline{\text{Ves}} \) Give Year or Dates: 2006−2012 Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ∐ Yes 2 XNo Specify: Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) United States Elementary/Secondary (0-12) College (1-4 or 5+) Corporal Marine Corp. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Brian Hugo Simonsen Deborah Barker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6009 Netherton Street, Centreville, VA 20120 Barbara Ann Simonsen-Wife Date UNK . | 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1X Burial 2 Cremation 3 Removal from State Quantico National Cem. Triangle, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility EVERLY FUNERAL HOME 23a: Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or near failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

MULTI - SISTEM OR CAN FAICULE

Due to (or as a consequence of 10565 Main Street Fairfax, VA 22030 100374 Approximate Interval Between Onset and Death **Physician** TWULTI - SYSTEM

Due to (or as a consequence of). /Medical MD Examiner RESPIRATOR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner ri and SMOKE The law requires that the death certificate be executed IN Due to (or as a consequence of) the burial-Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 🗌 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) 2 □ No 9 Unknown signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown ACIDOSIS 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an AMPHETAMINE autopsy has this certificate Physician: director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ completely filled in by the funeral 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28b. Time of Medical Certification: I or Attending P after death. Director; After t 1 Natural
2 Accident 5 Pending investigation (Month, Day Year) 2 No 04:26AM Irapped in Burning Vehicle 1 Tes 3 Suicide 6 ☐ Could not be . Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide Annapolis, Garage 1203 Fort Hill Court To the Hospital or within 24 hours a To the Funeral D 1 x Certifying Physician: To the best o my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

State Registrar

31. Date filed (Month, Day, Year)

26. frome and address of per un

29b. Signature and title of certifie

(check only

one)

who completed cause of death (Item 23a) (Type, Print

DHMH 17 Rev 1/2001

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

4940 Eastern Avenue, Baltimore, MD, 21224

12,2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Arnold Lee Silcott 20. 2012 7:45 A M March Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 2805 Elnora Street Wheaton Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Months Min Hours **Director** 228-16-0355 1 **X**M 2 □ F 87 May 19, 1924 Virginia Usual Residence of Decedent show at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f Maryland | Montgomery Wheaton 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o Funeral 2805 Elnora Street 20902 United States death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ð Yes 2X No Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 Tes 2 No Specify: Specify: Caucasian 3 Widowed 4 Divorced Completed Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working ed other than "event, the Med life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) <u>Tree Surgeon</u> Carpentru Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) alth and Mental H Charles Merle Silcott Louisa Mae Thomas t. Page 1 and 2 should be trment of Health and Men rtant; If item 27 is marke jury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Garcia, Daughter 2805 Elnora Street, Wheaton, Maryland 20902 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Durial 2 Cremation 3 Removal from State Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Crematory 3/22/2012 Brentwood, Maryland 21. Signatu o Funeral Service Licensee 22. Name and Address of Facility Simple Tribute MO1102 1040 Rockville Pike. Rockville. Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Ph_sician/ immediate Myocardial infarction disease or condition Medical resulting in death) Examiner Coronary artery disease years Sequentially list conditions, Examine Dusity for as a consequence of, if any, leading to immediate cause. Enter Underlying that the death certificate be executed Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by or Attending Physician; The law requires atrial fibrillation, chronic kidney disease III, 1 ☐ Yes 2 😿 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an hypertension page 2 autopsy perform death? Yes 2 X No 2 No 25. Was case referred to medical Be Hospital Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 Yes 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No filled in by the Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number D02338 March 21, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Richard Delaney,

MAR 22 2012

3929 Ferrara Drive, Wheaton, Maryland 20906

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 0050M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Min **Director** 578-42-9193 1 □ M 2 **X** F 77 09/15/1934 Washington, DC 28a-f shov with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director Maryland North Beach Anne Arundel 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ural", or items 23a o Funeral 7016 Dover Avenue 20714 u.s.A. death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: Caucasian "natural", Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Retailer Fragrances of Health and Mental Hygie If item 27 is marked other r other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ George Trakas Penelope (Unascertainable) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 5602 East Oakhurst Way, Scottsdale, Arizona 85254 George Thomas Christakos - Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🗶 Burial 2 🗆 Cremation 3 🗆 Removal from State Gate of Heaven Cem. 03/24/2012 Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home. Inc. NOI 244 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line. MONAGE Immediate Cause (Final h sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list condition Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 2 No the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 2 No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of page 2 this certificate has autopsy performed' death? 2 No Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural work? 5 Pending s after death. the Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) within 24 hours a

To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner To be best of my knowledge death occurred at the time date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check 3 Certifying Nurse Practitione e best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated and title of cert 29c. License number larc TI M se of death (Item 23a) (Type, Print) 44 CDEFENSE

Registrar

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. = For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ William Henry Sharpe 4:40 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** P.G. Lanham Doctors Community Hospital . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Months (Month, Day, Year) **Director** 240-72-2563 69 1 M 2 D F 07-11-1942 NC items 23a or 28a-f show her must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director 1 X Yes 2 No P.G. Clinton MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 20735 6411 Springbrook La. U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, "natural", or ite Black, White, etc by 1 Never Married 2 X Married 1 Yes 2 If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 filed within 72 hours after 2 N 1 Yes 2 No Specify: Black Specify: 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 72 t Department of Health and Mental Hygiene. Important: If fem 27 is marked other than "na any injury or other traumatic event ***. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Hospital Cook Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Andrews Juanita Frank Sharpe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6411 Springbrook La./Clinton, MD 20735 Flora F. Sharpe / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, Quantico National 3-26-2012 Triangle, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Latimore Funeral Services, PA Sig af ire of Funeral Service Licensee Williamed ames 2818 E. Baltimore St./Baltimore, MD 21224 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Bladder disease or condition Medical resulting in death) **Examiner** Sequentially list conditions Examine Due to (or as a co if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed and Due to (or as a consequence of): burialattending physician Physician/Medical P.O. Box 68760 the as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death for use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death signed by the at I be detached for Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? γ Records, 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 autopsy perform 2 🗆 No certificate 1 Yes Division of Vital or Attending Physician: 25. Was case referred to medica director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ျပ funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After of completely filled in by the funer 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar LANAM

20706

30. Name and address of person who completed cause of death (Item 23a) (Type,

e

Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 18 2012 John. Sandor March 6:30 A Henry Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carriage Hill Nursing Center Bethesda Montgomery 9. Birthplace (State or Foreign Country) If Under 1 Year 8. Date of Birth Social Security Number 7. Age (In vrs. last birthday If Under 24 Hrs. **Funeral** Days (Month, Day, Year 1 X M 2 D F Months Hours Min Yrs Colorado Director 348-05-9543 June Usual Residence of Decedent or 28a-f show 10b. County be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 Yes 2 X No Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 5838 Edson Lane United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ō à 1 Never Married 2 Married X Yes 2 NO Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: "natural", 3 Widowed 4 Divorced Specify: Completed White WW II 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working permit, Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other trainments. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Department of 5+ Agriculture Lawyer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Louis Sandor Magdeline Maliscak 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeffrey Smith/Nephew 10404 Farnham Drive, Bethesda, Maryland 20814 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crem. 3/19/2012 Alexandria, Virginia 21. Signature of Funeral Service Licens 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Dr., Gaithersburg, MD. 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ 2 MENTI disease or condition Medical resulting in death) Due to (or as a consequence of): Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) physicans the burialtrageit Cause (Disease or linjury that initiated events resulting in death) Last attending physician and Due to (or as a consequence of) Physician/Medical IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Pregnant at time of death the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ρ 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performe 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospita Other: 2 No 1 Tes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 28a. Date of injury (Month, Day, Year) Manger of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 24 hours after deat Funeral Director:

4 Homicide	determined	28e. Place of Injury - At home, farm, street, fa building, etc. (Specify)	actory, office	28f. Location (City or To	(Street and Number or Rural Route Number, wn, State)	
(Check 2	🛚 🔛 Medical Examine	ian: To the best of my knowledge, death occur r: On the basis of examination and/or investigation Practioner: To the best of my knowledge, death	on, in my opinion, death occurred a	t the time, date	and place, and due to the cause(s) and manner state	d.
29b. Signature and	title of certifier	Bus, mo	29c, License number	7	29d. Date signed (Month, Day, Year) 3(19/12	

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10110 Molecular Drive, Suite 206, Rockville, Maryland 20850 Truong Bao, M.D.,

State Registrar

filled in by

pleted f within 2 10

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 4:200 M (AKA) Jeannie H. Seidman 2012 Jeanne H. Seidman Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Hebrew Home of Greater Washington Rockville Montgomery Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗓 F Months Hours 097067 197 8 104-01-5350 Director 93 Pennsulvania Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Me fical Ex miner must be notified at 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10c. City, Town or Location 10d. Inside City Limits Funeral Director Rockville Maryland Montgomery 1 Yes 2 X No 10f. Zip Code 10g. Citizen of What Country? 6121 Montrose Road 20852 U.S.A 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🛣 No
If Yes, Give Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. 3 X Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be (17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Hecht Rebecca Felsenstein 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joel C. Seidman - Son 1441 Madison Street, NW, Washington, DC 20011 Department of Healt Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🛭 Burial 2 🗆 Cremation 3 🛣 Removal from State Cedar Park Cemetery 03/22/2012 Paramus, New Jersey 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disea Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, Examiner Due to (or as a consequence of, n any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial researched for the same and the sam Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 1 Yes completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy performe 1 Yes 2 No 25. Was case referred to medica Certificate: To Be 26. Place of Death (Check only one) examiner? 2 XN0 Other: 4 Nursing Home 5 Residence 6 Other (Specify 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 1 Yes 2 No Investigation Accident 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) the 29b. Signature and title of certif 29d. Date signed (Month, Day, Year) 10 0018084 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6121 NONTROSE 140 20852 B1. Date filed (Month, Day, Year)
MAR 2 5 2012 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 0 Physician/ 2 67 2 March 11:50 PM Irving Silver Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Vantage House Nursing Home Columbia Howard Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral Director** 146-22-3749 1 🛛 M 2 □ F 95 11/24/1916 New York 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director items 23a or 28a-f s ner must be notified MD Howard Columbia 1 🗆 Yes 2 🕺 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5400 Vantage Point Road, #811 21044 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. "natural", or iter edical Examiner Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 3 Widowed 4 □ Divorced 1 Tes 2 No Specify. Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done duning most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "i any injury or other traumatic event, the Med Once. Elementary/Secondary (0-12) College (1-4 or 5+) Chemist Department of the Navy Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Charles Silver Lena Yourman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Silver, Son 14070 Stevens Valley Court, Glenwood, MD 21738 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt. Lebanon Cemetery 03/13/2012 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Adelphi. Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Hines-Rinaldi Funeral Home. Inc.
11800 New Hampshire Ave., SilverSpring. MD 20904 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Metastatic Lung Cancer disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Exami To the Hospital or Attending Physician; The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of): resulting in death) Last burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death Yes 2 No be detached i 9 Unknown g Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2**X X**N 2 🗌 No __ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: မ 4 X Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 🔁 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation filled in by the after death 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide within 24 hours a To the Funeral I Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. npletely (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) March 12, 2012 D47447

State Registrar 30. Name and address of pe

Andrew Lazros.

31. Date filed (Month, Day, Year)

MAR 14

#103. Columbia. Maryland 21044

pleted cause of death (Item 23a) (Type, Print)

Cedar Lane,

32. Registrar's Signature

6334

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar

1 4 2012

08487

2

03080

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra MFND#23a(b)perMD,3/20/12;BMW,MbCo Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 1^{Day} 201^{Year} 11:30 PM Claire Marie Seebode Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Montgomery 19230 Liberty Heights Lane Germantown 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 🕱 F Days Jan 1,7 ay 1,921 Hours ^{Cauntry} Pennsylvan<u>ia</u> 91 Director 176**-**18-0827 Usual Residence of Decedent 28a-f shov 10a. State 10b. County filed within 72 hours after death with the Maryland items 23a or 28a-f sho her must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Montgomery Germantown 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? Funeral USA 19230 Liberty Heights Lane 20874 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Medical Examiner Black, White, etc. 9 by 1 Never Married 2 X Married ☐ Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White Specify: "natural", Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 }
Department of Health and Mental Hygiene.
Important: If frem 27 is marked other than "na any injury or other traumatic event". (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျပ Julius Magerl Margaret Carlin Schmidt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Calvin Charles Seebode (Spouse) 19230 Liberty Heights Lane, Germantown, MD 20874 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) of Heaven Cem. 03/15/2012 |Silver Spring, MD Gate DeVol Funeral Home 21. Signature of Funeral Service Licenses 22. Name and Address of Facility MO1202 10 E. Deer Park Drive, Gaithersburg, MD 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician disease or condition resulting in death) Respiratory Failure Days Medical Due to (or as a consequence of) Examiner Terminal Cardiac Arrythmia Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a consequence of attending physician and that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy 3 L in the past 12 months? 1 ☐ Yes 2 X No Pregnant at time of death Month Day Year 5 Other (specify) the a be detached Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 \square Yes 2 \square No 3 \square Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an performed?

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 this certificate has funeral director, within 24 hours after death.

To the Funeral Director: After of the funeral of th To the Hospital of within 24 hours a To the Funeral D

Be 욘

Certificate:

Medical

only one) 29b. Signature and title of cert

31. Date filed (Month, Day, Year

		TLI fes Z LINO						
25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒No	26. Place of Death (Chec Hospital: 1 ☐ Inpatient 2 ☐ EF/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Ho	k only one) ome 5 X Residence 6 □ Other (Specify)						
27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigatior 3 Suicide 6 Could not b 4 Homicide determined	28a. Date of injury (Month, Day, Year) 28b. Time of injury M 28c. Injury at work? 1 Yes 2 No	28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Murse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								

1,6065

29d. Date signed (Month, Day, Year)

March 13, 2012

erson who completed cause of death (Item 23a) (Type, Print)

9613 Bellevue Drive, Bethesda, MD 20814 Amy Schiffman, M.D.,

State Registrar

10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month E. E. Sanchez Hilary 2012 4:30 March Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Casey House - Montgomery Hospice Montgomery Rockville Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Min. (Month 87 **Director** 525-28-5547 1 X M 2 □ F New Mexico May 16,1924 Usual Residence of Deceden 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland notified at Director 28a-f Chevy Chase 1 Yes 2 XNo MD Montgomery 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? ms 23a or Funeral 555 Friendship Blvd 20815 United States items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, ed other than "natural", or ite event, the Medical Examiner d Forces Black, White, etc. þ 1 X Yes 2 If Yes, Give Year or Dates 2 No 1943-1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injuy or other traumatic event, the Medical Examinant injuy or other traumatic event, the Medical Examinant injuy or other traumatic event, the Medical Examinant in the Medical Examination in the Medical Examination in the Medical Exam Baltimore, Maryland 21215-0036 1 🔀 Yes 2 □ No Specify: Spanish Specify: White 3 ▼ Widowed 4 □ Divorced 1946 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired)

Secret Service White House Police College (1-4 or 5+) 5+ Elementary/Secondary (0-12) U.S. Secret Service Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ၉ Dolores Baca Casimiro Sanchez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maria Teresa Gould Val(Daughter) 1596 Andover Lane, Frederick, MD 21702 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ott once, Date 1 \underline{X} Burial 2 \square Cremation 3X Removal from State Raleigh Memorial Cemetery March 2012 24, 4 ☐ Donation 5 ☐ Other (Specify) Raleigh, NC 21. Signature of Funeral S 22. Name and Address of Facility DeVol Funeral Home, 10 East Deer Park Drive, Gaithersburg, MD 20877 1 Jude M01117 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph. sician/ Convestive Heart Failure disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death.

To the Funeral Director; After this certificate has been signed by the attending physicis. Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Left Sided Heart Failure 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

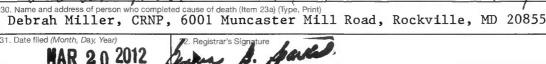
1 Yes 2 No 24a, Was an page 2 Dementia performed Yes 2 v No 25. Was case referred to medical filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 X Other (Specify) Hospital 1 ☐ Yes 2 X No ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred XNatural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

341

31. Date filed (Month, Day, Year, MAR 20 2012 Registrar

(Check

only one 29b. Signature and title of certifie



Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

R143201

29d. Date signed (Month, Day, Year)

29c. License number

3 😾 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First Middle | ast) 2 Date of Death 3. Time of Death Day 2012 Physician/ March 09 6:40pm Annette D. Steiner Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Village Health Care Montgomery Village Montgomery Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Hours 213-46-6821 **Director** 1 □ M 2 🗓 F 94 June 26, 1917 Maryland Usual Residence of Decedent or 28a-f show notified at with the Maryland 10a State 10b. County 10c. City, Town or Location 10d Inside City Limits Director 1 Yes 2 X No Maruland Montgomery Village Montgomery 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? ral", or items 23a o Examiner must be Funeral 19310 Club House Road, Apt. 514 20886 u.s.A. death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 X No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married by hours after Maryland 21215-0036 1 ☐ Yes 2 No Specify: 'natural", Specify. 3 X Widowed 4 Divorced White Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working than, life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Il Hygiene. the Librarian Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H ည Israel Danker Martha Nathanson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trat 10001 Dellcastle Rd., Montgomery Village, MD 20886 Roslyn Price - Daughter Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Judean Memorial Grdns 03/12/2012 Olney, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home. Inc. 232 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph_sician/ Pneumonia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Congestive Heart Failure Sequentially list conditions, Examiner If a y leading to in model cause. Enter Underlying Cause (Disease or injury that initiated events 3 requires that the death certificate be executed Urinary Tract Infection Due to (or as a consequence of) resulting in death) Last Physician/Medical <u>Deep Vein Thrombosis</u> Division of Vital Records, P.O. Box 68760 nding p. se as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Bladder Cancer 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛛 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an To the Hospital or Attending Physician: The law autopsy performed' death? 2 No Yes 2 No 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Hospital Other: 2 X No မူ 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred After t 1 X Natural 5 Pending 1 Yes 2 No within 24 hours after death.

To the Funeral Director: A completely filled in by the f Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 □ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifi P D41102 March 16. 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Vinu Ganti,

MAR 19 2012

31. Date filed (Month, Day,

M.D..

Germantown, Maryland 20874

19\$29 Doctor Drive,

			For State Registrar		State of M	aryland	•	artment of H tificate of D		d Mental H	lygien Reg. N	201	2 0 8	
	Physicia	n/	1. Decedent's Name (First							2. Date of	Death		3. Time of Death	
	Medic Examin	al	Claude 4a. Facility Name (if not in	Albert institution, give s	Swanson	l .		4b. City, Town, or	Location of De	March		12 2012		
-	Examin	ei	Shady Grov			ital		Rockv		aur	Montgomery			
	Funeral Director		5. Social Security Numbe 578–46–4163	1 [X X M 2 □ F 7. Ag	e (In yrs. Ias 76	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi		Day Vear	g. Bi C. 935 Wasl	rthplace (State or Foreign puntry) nington D.C.	
	and show	or	Usual Residence of Dece 10a. State 10b	edent c. County		10c. City,	Town or Loc	ation					10d. Inside City Limits	
	Maryl 28a-f otifie	Director	MD	Montgo	mery				mantown	ı			1 ☐ Yes 2 🔀 No	
	ith the 23a or st be r	ralD	10e. Street and Number 18623 Glen	Willow	Way			10f. Zip Code	874		10g. (Citizen of What C United	*	
36	ifter death v ", or items aminer mu	by Funeral	11. Marital Status 1 Never Married	2 X Married	12. Was Decedent I Armed Forces? 1 X Yes 2 If Yes, Give	105	74-1	Vas Decedent of His Yes, specify Cubar	spanic Origin? n, Mexican, Pue	(Specify Yes or Nerto Rican, etc.)	0-	14. Race - Am Black, Whi	erican Indian,	
21215-0036	hours a 'natural'	Completed		Divorced Decedent's Ed only highest grad	Year or Dates.		16a. Deced	ent's Usual Occupa	ition	e atria a	16b.	Specify: Kind of Business		
2121	vithin 72 liene. er than ' the Me		Elementary/Secondar		College (1-4 or 9	5+)	life. Do	ind of work done d DNOT use retired) ilding En	_	rorking		tional Institute of ience and Technology		
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be	17. Father's Name (First,	, ,						lame (First, Midd	le, Maide	n Surname)		
Maryland			Claude A1 19a. Informant's Name/F				10b Mailin	g Address (Street a		ira Iaca			(in Cada)	
		1 1	Mary C. Swa					3 Glen Wi						
Baltimore,			20a. Method of Dispositi 1 🌠 Burial 2 □ Ci 4 □ Donation 5 □	remation 3		20b. Pla Gat	ce of Disponetery, cren e of	sition (Name of natory or other place Heaven emetery	Maı	cch 16, 2012		Location - City o		
Bal	permit Depar Impor any in		21. Signature of Euneral	Service License	2/1/		D 22	Name and Addres. eVol Fune Gait	s of Facility ral Hor hersbur	ne, 10 E	ast 0877	Deer Par	ck Drive,	
	Phylician Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	lure. List only on	a. Ca1 Due to (or as	e. Cdioge a conseque	Do not ente	r the mode of dying	ı, such as cardi				Approximate Interval Between Onset and Death	
09.	cate be executed physician and sthe burial result.	edical Examiner	Sequentially list condition if any, leading to immed cause. Enter Underlying Cause (Disease or iinjur that initiated events resulting in death) Last	diate All	Due to (or as	a conseque ronary	nce of): Arte	ry Diseas						
. Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burn the purity of the funeral director.	by Physician/Me	IF FEMALE: 23b. Was decedent preg in the past 12 mont 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	ths?	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Fetal	death 3 🗌	Ectopic pregnanc	y		-	23d. Date of de Month	elivery Day Year	
ls, P.O.	uires that the signed by ald be deta	ed by PI	Part II. Other significan	at conditions co	ntributing to death t	out not resul	ting in the u	nderlying cause giv	en in Part I.				to the cause of death?	
Division of Vital Records,	The law requate has bee page 2 shou	Completed								pe	as an itopsy erformed?	prior to death?	utopsy findings available completion of cause of	
ital	ician: certific rector,	Be	25. Was case referred to examiner? 1 ☐ Yes 2 🗶 No	6	Hospital:			Othe	ce of Death (C					
of V	g Phys er this ieral di	te: To	27. Manner of Death		28a. Date of inju	ury 2	8b. Time of	28c. Injury	at U Nursing			6 Other (Spe ury occurred	ecify)	
vision	or Attendin fter death. iirector: Aft n by the fur	Medical Certificate:	2 Accident	Pending Investigation Could not be determined		ury - At hom	injury ne, farm, stre	M 1 □	Yes 2 No		n (Street a		ural Route Number,	
Ō	Hospital of the Hours a Funeral Detect filled i	ledical ((Check 2 🔲 🖡	Medical Examir	ician: To the best of ner: On the basis of a e Practioner: To the	examination a	and/or invest	igation, in my opinio	n, death occurre	ed at the time, dat	e and pla	ce, and due to the	cause(s) and manner state	
	To the within to the comp	2	29b. Signature and title of			. soci or my f	omouge, c	29c. License		p.ace, and due to	_	Date signed (Mon	th, Day, Year)	
			30. Name and address of Usha Kiran				, , , , ,	,	r Drive	, Rockv:	ille,	, MD 208	50	
	Sta Registra		31. Date filed (Month, Da		32. Registr	ar's Signatu								
			111111		1 Parties	-	7							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

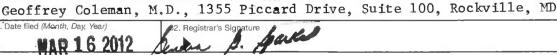
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 15, 2012 Year Physician/ Eleanor SACKS 12:55 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Montgomery Chevy Chase 8100 Connecticut Avenue #1520 8. Date of Birth (Month, Day, Year) October 21 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months 1 M 2 XF 1917 Indiana Director 94 103-01-0189 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Chevy Chase Montgomery Maryland 1 Yes 2 TNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20815 United States 8100 Connecticut Avenue #1520 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give þ 72 hours after Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 X No Specify: "natural", 3 XWidowed 4 Divorced Completed Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Education 5 +Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental ဂ္ Harriet Krauss Sol Golde 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4 Magnolia Parkway. Cheyy Chase, MD 20815 4 Magnolia Parkway, Chevy Chase, MD f Health aitem 27 Stephen Sacks, Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If it any injury or o 1 Burial 2 Kermation 3 Removal from State Metropolitan Crematory 03/15/12 Alexandria, VA 4 Donation 5 Other (Specify) 21. Signature of Funetal Se Toroninakas Hebrew Funeral Home 20012 254 Carroll St., NW, Washington, DC 23a. Part 1. Elect the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Coronary Atherosclerosis Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin and Cause (Disease or linjury that initiated events death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physiciar for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Pneumonia Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t page 2 s autopsy performed? 2 XN 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No 5 Pending 2 Accident
3 Suicide

Box 68760 P.O. Records, Division of Vital Hospital or Attending in 24 hours after death.

Certificate: Investigation
6 Could not be he Funeral Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. To the Hos within 24 h To the Fur completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) per March 15, 2012 D 37142

State Registrar 31. Date filed (Month, Day, Year)



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

20850

			se Type or Pri	i nt in Black laryland / De			-	•	ble.		
		For State Registrar		-	ertificate of			Reg. No. 2	12 1018		
Physician		1. Decedent's Name <i>(First, Middle,</i>	rnard SAMUE	LS			2. Date of De Month March		Year 3. Time of Death		
Medica Examina		4a. Facility Name (if not institution,	give street and number)		4b. City, Town,	or Location of Dea		4c. County of			
Franci		Renaissance Gar 5. Social Security Number		ge (In yrs. last birthda		r Spring	S. 8. Date of Bir		Georges 9. Birthplace (State or Foreign		
Funeral Director		490-10-8084 Usual Residence of Decedent	1 M 2 □ F	93 Yrs.	Months Days		1. (Month. Da	ay, Year)	Country) Missouri		
yland -f show ed at	ctor	10a. State 10b. County		10c. City, Town or					10d. Inside City Limits		
the Mar or 28a oe notifi	Director	10e. Street and Number	e Georges	Silver	Spring 10f. Zip Code		I	10g. Citizen of W			
ms 23a must k	Funeral	3160 Gracefield		5 1 110 L		0904		United			
, or l	by	 11. Marital Status 1 ☐ Never Married 2 ☐ Marries 3 ☐ Widowed 4 ☐ Divorced 	12. Was Decedent & Armed Forces? 1 X Yes 2 If Yes, Give Year or Dates.	1942_	3. Was Decedent of If Yes, specify Cut 1 ☐ Yes 2 🏋 N	oan, Mexican, Pue		11111400	- American Indian, , White, etc. white		
/2 hou in "natu Medical	Completed	15. Decedent (Specify only highes	st grade completed)	(Gi	cedent's Usual Occu ve kind of work done DO NOT use retired	during most of wo	orking	16b. Kind of Bus	iness/Industry		
ygiene. her tha ht, the N	a)	Elementary/Secondary (0-12)	College 31-4 or 5		wner/Oper	ator		Scrap M	letal		
l be filed lental H rked ot tic ever	To B	17. Father's Name (First, Middle, La William Sa	,			1	_{ame (First, Middle,} n ie Sor k:	(First, Middle, Maiden Surname)			
should and N is ma raumat		19a. Informant's Name/Relationshi	ip (Type, Print)		ailing Address (Stree	t and Number or Fi	Rural Route Numbe	er, City or Town, Sta	1.		
f Health item 27 other t		Edward Samuels, 20a. Method of Disposition		20b. Place of Dis	W. 94th	St., #12	-H, New		10025 City or Town, State		
Page Page ant: If it		1 X Burial 2 Cremation 4 Donation 5		cemetery, c	rematory or other pla id Memori				ywood, FL		
permit. Departi Import any inj once.		21. Signature o Furleral Sevice Lit	censee		Forchinsk	ys Hebnew	Funeral	Home			
223	_	23a. Pa 1 Pnter the disease, or c shock, or heart failure. List or	complications that caused	d the death. Do not e	254 Carro enter the mode of dy		-	AMILE STATE	Approximate		
hysician/ Medical		Immediate Cause (Final disease or condition resulting in death)	_ a Arterio	sclerotic	Cerebra1	Vascula	r Diseas	e	Interval Between		
Examiner			Due to (or as a Hyperte	a consequence of):					20 Years		
(a)	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	D. —	a consequence of).					S		
		that initiated events resulting in death) Last									
physici s the bu	edica										
been signed by the attending physician should be detached for use as the burit		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23d. Date Mont	of delivery h Day Year							
ned by	by Ph	Part II. Other significant condition	ns contributing to death b	out not resulting in the	e underlying cause g	given in Part I.	23e. Did to	obacco use contrib	oute to the cause of death?		
sen sign	ted k	Diabetes Type 2)				. 1 🗆	Yes 2 ☐ No 3	Probably 4 Unknown		
cate has	Completed	Cardiac Arrhyth	mias				24a. Was autor perfo 1 Yes	psy pri prmed? de	ere autopsy findings available or to completion of cause of ath? Yes 2 No		
s certifi directo	lo Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:	ent 2 ER/Outpat	Int	Place of Death (Chi		dence 6 Other	/Chariful		
th. : After this e funeral		27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigation	28a. Date of inju (Month, Day	ry 28b, Time	of 28c. Inju	ıry at		now injury occurred	•		
. 0	II Certificate:	3 Suicide 6 Could not 4 Homicide determin	ot be	ury - At home, farm, s c. (Specify)	street, factory, office		28f. Location (S City or Tow		or Rural Route Number,		
n 24 hour	Medical	(Check 2 Medical Ex	Physician: To the best of caminer: On the basis of e: Nurse Practitioner: To the	xamination and/or inv	estigation, in my opin	ion, death occurred	d at the time, date a	and place, and due t	o the cause(s) and manner stated		
201		29b. Signsture and title of certifier 29c. License number 29d. Date signed (Mgnth, Day, Year) 29c. License number 29d. Date signed (Mgnth, Day, Year)									
		30. Name and address of person w				Cilver Cr	ring MD	20904	·		
State	•	Eileen Gemmell,	3€. Registra	ar's Signature	u ruau, s	oriver sp	71 1119 111D	20704			
Registra	r	MAR 27 20	112 Centra	A. 90	Marie .						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MAY EMMA BUTLER SWANN MARCH 2012 Medical 4:00A **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death RESIDENCE. 10873 LA PLATA ROAD LA PLATA CHARLES Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 MARYLAND **Funeral** 8. Date of Birth (Month, Day, 1 M 2 XF 79 Months Days Min. (Month, Day, AUGUST **Director** 220-32-5172 20.1932 Usual Residence of Decedent or 28a-f show notified at 10b. County within 72 hours after death with the Maryland 10c. City. Town or Location Director 10d. Inside City Limits 1 Yes 2X No MARYLAND CHARLES LA PLATA ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23a o the Medical Examiner must be Funeral 10873 LA PLATA ROAD 20646 UNITED STATES 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify: 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 X No δ 1 __Never Married 2 Married 3 ☐Widowed 4 ☐ Divorced If Yes, Give Year or Dates Specify: BLACK Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. I o**ther than** " Elementary/Seconday (0-12) College (1-4 or 5+) CUSTODIAN EDUCATION 7th GRADE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 1 and 2 should be filed if Health and Mental Hitem 27 is marked of other traumatic ever JAMES C. BUTLER ELIZABETH EDITH PROCTOR BUTLER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MAY EMMA BUTLER SWANN/ SELF 10873 LA PLATA ROAD, LA PLATA, MARYLAND 20646 permit. Page 1 and Department of Healt Important: If item 3 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 KBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) ST. IGNATIUS CEMETERY MARCH 24,2012 HAPEL POINT, MARYLAND 21. Signature 64-Formeral Service Libertsee Name and Address of Facility
THORNTON FUNERAL HOME TO A HEAD, MARYLAND 20640
3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 ▶ LEON THORNTON M00582 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical that the death certificate be use as IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Petal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 wonths?
1 Yes 2 No Day Year Pregnant at time of death ate has been signed by the a page 2 should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Niknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No Yes 2 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work?
1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Mor

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 22 Pay 2012 Year MARCH HERMAN J. SCHELTS, JR. 4:10 p M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 208 Maplewood Lane Galena Kent . Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 ★ M 2 □ F Months Days Hours Min Day, 1926 215-20-1992 Yrs Director June Usual Residence of Decedent show 10a. State 10b. County within 72 hours after death with the Maryland aţ 10c. City, Town or Location 10d. Inside City Limits Director ıral", or items 23a or 28a-f s Examiner must be notified Kent Galena 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 208 Maplewood Lane 21635 U.S.A. 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, med Forces Black, White, etc "natural", or by 1 Never Married 2 Married 1 X Yes 2 If Yes, Give Year or Dates. 2 □ No 1946 Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White 3 ₩ Widowed 4 □ Divorced Specify: Completed -1947Medical Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry De filed with.
Mental Hygiene.
'ed other than "r (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Carpenter Self-employed 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental h permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked of any injury or other traumatic eve ance. ပ Ella O'Neal James Herman Schultz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 208 Maplewood Lane Galena, MD. 21635 Wayne Schelts (son) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Burial 2 Cremation 3 Removal 4 Donation 5 Donat Galena Cemetery 3/28/12 Galena, MD. 22. Name and Address of Facility
Galena Funeral Home of Stephen L. Schaech
118 West Cross St. Galena, MD. 21635

ADDRESS:
ADDRESS Signature **L**uneral Se M00510 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, o heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final MILWES Lewor Physician/ SMAGE eno disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and the attending physician and hed for use as the burial-transit Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Li Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Day Year cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 110 1 Yes 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Hospital Other: Certificate: To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? (Month, Day, Year) Natural 5 Pending 1 🗌 Yes 2 🗆 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of e amination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State

only one

29b. Signature a

d title of certif

Michael E. Peimer,

APR 0 2 2012

nd address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

32. Registrar's Signatu

Registrar

122 Speer Rd.

D0060301

Chestertown, MD. 21620

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ Month 03 19 Anna Mary Shlagel 2012 4:49 Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4c. County of Death La Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Hours **Director** 219-74-1047 1 □ M 2**X** F 91 D7/31/1920 Maryland Usual Residence of Dece or 28a-f show notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No Waldorf Maryland_ <u>Charles</u> ò 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? be ral", or items 23a Examiner must be Funeral 5503 Jeffrey Circle 20601 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or ģ 1 X Never Married 2 - Married 1 ☐ Yes 2 🏋 No If Yes, Give 21215-0036 1 ☐ Yes 2 🗓 No Specify: White Completed 3 Divorced 4 Divorced Year or Dates Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2nd Disabled Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alois Shlage1 Mary Oberleitner Shlage1 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Norma Berry / Niece 5503 Jeffrey Circle Waldorf, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 5 1 💢 Burial 2 🗌 Cremation 3 🗐 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Peter's Cemetery 3/23/2012 Waldorf, MD 21. Signature of Funeral Service Licensee

Hauxim C. Echal M00817 22. Name and Address of FacilitBrinsfield-Echols Funeral Home, P.A. 30195 Three Notch Road Charlotte Hall, MD 20622 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on Immediate Cause (Final Physician/ **Medical** resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions. Examine rany, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) ohysician and the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death Month 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an nas autopsy perforn After this certificate ☐ Yes 2 KNo Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospita 2 No 잍 1 Yes Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred **Natural** 5 Pending work' Accident Investigation 24 hours after deat Funeral Director; Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier who completed cause of death (Item 23a) (Type, Print) OUT LINE CENTER 12070

つべつ

Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Day 2012 Physician/ March 17, Rose Moniz Titcomb 4:58 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Collingswood Nursing Home Rockville Montgomery 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 010-20-9107 (Month, Day, Year, Hours **Director** 1 □ M 2 🖺 F May 24, 1925 86 Yrs. Massachusetts or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery Gaithersburg 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9607 Low Meadow Drive 20882 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Armed Forces?

1 Yes 2 No 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married within 72 hours after Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give Specify. 3 Widowed 4 Divorced Completed Year or Dates White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) nit. Page 1 and 2 should be filed within 7: artment of Health and Mental Hygiene. octant. If item 27 is marked other than injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) 12 Clerk Phone Company Be ⁷. Father's Name *(First, Middle, Last)* Manuel Moniz 18. Mother's Name (First, Middle, Maiden Surname) 2 Mary L. Pacheco 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeffrey S. Titcomb (Son) 9607 Low Meadow Drive, Gaithersburg, Maryland 20882 20b. Place of Disposition (Name of Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State cemetery crematory or of All Souls Cemetery 1 🔀 Burial 2 🗌 Cremation 3 🗆 Removal from State Department or Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) 2012 Germantown, Maryland 21. Signature of Funeral Service 22. Name and Address of Facility DeVol Funeral Home, (M00689) 10 East Deer Park Drive, Gaithersburg, MD 20877 Inherthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest both or heart failure. List only one cause on each line. Par Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Failure to Thrive Medical Due to (or as a consequence of) Examiner Dementia Sequentially list conditions cause. Enter Underlying
Cause (Disease or injury Due to (or as a consequence of) The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician at the burial Physician/Medical P.O. Box 68760 as IF FEMALE: ase 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 month 1 Yes 2 No Month Day Year Pregnant at time of death the 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Coronary Artery Disease Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performe 2 No 1 🗌 Yes Yes 2 X No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Tyes 2 X No Other: 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 \square Pending 1 X Natural 1 Tes 2 No 2 Accident 3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical ☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
☐ In the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
☐ In the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
☐ In the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
☐ In the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
☐ In the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
☐ In the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
☐ In the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
☐ In the basis of examination and occurred at the time, date and place, and due to the cause(s) and death occurred at the time, date and place are the cause of the cau 29a. Certifier Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D62435 March 19, 2012

Registrar

State

31. Date filed (Month, Day, Year)

MAR 20 2012

Sayed Elsayyad, M.D., 10110 Molecular Drive, #206, Rockville, MD 20850

no completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ Ralph 2012 3:15 a M Elliott Tobiassen March Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Rockv111e Montgomery 14105 Manorvale Road If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 82 578-36-4405 Director 1 🏝 M 2 🗆 F Yrs. Dec. 25, 1929 NY Usual Residence of Decedent 10d. Inside City Limits 28a-f shov items 23a or 28a-f shoner must be notified at 10a. State 10b. County 10c. City. Town or Location within 72 hours after death with the Maryland **Funeral Director** 1 Yes 2X No MD Montgomery Rockville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 14105 Manorvale Road 20853 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 No Black, White, etc. o 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify. res, Give Year or Dates 1953-1977 "natural", 3 Widowed 4 Divorced Completed Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ns
any injury or other traumatic event, the Medic
once. Central Intelligence Elementary/Secondary (0-12) College (1-4 or 5+) Security Officer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Einar Tobiassen Judith E. Olsen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty L. Tobiassen/Wife 14105 Manorvale Road, Rockville, MD 20853 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State March 19, Gate of Heaven Cemete**r**y Silver Spring,MD 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility Francis J. Collins Funeral Home 500 University Blvd. W. Silver 21. Signature of Funeral Service Licenses Home Inc. lver Sprin MD 20901 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Multiple Myeloma Phylician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to minimisarate cause. Enter Underlying Examiner Due to (or se a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Other (specify) Pregnant at time of death signed by the at Id be detached fo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Diabetes Mellitus 1 Yes 2 XNo 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 2 K No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) filled in by the funeral director, Be examiner' Other: 4 Nursing Home 5 K Residence 6 Other (Specify) Hospital: 1 🗌 Yes 2 X No မ 1 Inpatient 2 Inpatient 3 Inpa 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at work? injury 1 Natural 5 \square Pending 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined

pletely D

State

Medical

29a. Certifier

(Check

only one)

3

Ram S. Trehan, MD

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D33224

29d. Date signed (Month, Day, Year,

March 15, 2012

29c. License number

#435

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Marc CEDRIC JOSEPH THOMPSON Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town or Location of Death 4c. County of Death **Examiner** Plata Charle If Under 1 If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 213-46-6140 **Director** 1 XM 2 F SEPT. 15, 1945 MARYLAND 66 Usual Residence of Deceden shov Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits ectric M1373 **Funeral Director** 1 Yes 2 No CHARLES INDIAN HEAD MD 10e Street and Number 10f. Zin Code 10g. Citizen of What Country? UNITED STATES 4021 INDIAN HEAD HIGHWAY 20640 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. δ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: BLACK 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) FEDERAL GOVERNMENT 9 TRUCK DRIVER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ ALICE JACKSON THOMPSON JAMES C. THOMPSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CEDRIC YATES/SON P.O. BOX 1, INDIAN HEAD, MARYLAND 20640 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) METROPOLITIAN CHURCH CEMETERY 3/23/2012 INDIAN HEAD, MD 21. Signature of Funeral Service License THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MD 20640 LYDIA C THORNION JOHNSON/MO0583 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ anonom disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury as the burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of): attending physiciar Physician/Medical P.O. Box 68760 IF FEMALE: use a yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnan.
Unknown Month Day Year 5 Other (specify) Pregnant at time of death signed by the ad Hospital or Attending Physician: The law requires that the t24 hours after death, Funeral Director: After this certificate has been signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA completely filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier 😪 rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I within 2 To the I only one 29b. Signature and title of certific eted ca use of death (Item 23a) (Type, Print nth, Day, Year)
NAR 15 2012 31. Date filed (Month, Day, Registrar's Signat State Registrar

State Registrar 30. Name and addres

WILLIAMSTOR

completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 2012 2:48рм Izaura Maria Vieira Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Bethesda Montgomery Suburban Hospital If Under If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours **Director** 579-98-7716 1 🗆 M 2 🗓 F July 23, 1945 66 Yrs. Brazil Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 309 Southampton Drive 20903 U.S.A. within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify 3 - Widowed 4 X Divorced Completed Latino Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Cleaning Business Owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ t. Page 1 and 2 should be f tment of Health and Menta rtant; If item 27 is marked jury or other traumatic ev Jose Hanri Vieira Maria Da Conceicao 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Silver Spring, Maryland 20903 309 Southampton Dr., Stacy Raley - Granddaughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Department or Important: If any injury or Lincoln Crematory 03/23/2012 | Brentwood, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hines-Rinulli Funeril Home, Inc. Sonature Fundant Service Licensee M00 709 02 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ Atherosclerotic Cardiovascular Disease disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, Due to (or as a consequence of): If a y, leach g to him ediate cause. Enter Underlying Cause (Disease or injury that initiated events rial rangiit Exami Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 5 Other (specify) 4 ☐ Pregnant at time of death 9 ☐ Unknown 2 🗶 No (3) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Diabetes of Vital Records. 1 ☐ Yes 2 🕱 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of Sarcoidosis after death.

Director; After this certificate has autopsy performed? death? 2 No 2 X No Yes To the Hospital or Attending Physician: filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 2 X No 1 Yes Certificate: To 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work?
1 ☐ Yes 2 ☐ No Division Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Medical 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner To the best of my let d at the time, date and place 29b. Signature and title of 29d, Date signed (Month, Day, Year) 30. Name and address of person who complete ause of death (Item 23a) (Type, Print)

State Registrar Natasha Haag.

MAR 19 2012

31. Date filed (Month, Day, Year

M.D.

C

\$600 Old Georgetown Road, Bethesda, Maryland 20814

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Deloris Ann Wetzel Physician/ 8:0 0 AM 03/19/2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death 7830 Friends Creek Road Frederick Emmitsburg If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours **Director** 208-24-2450 Usual Residence of Decede 1 🗆 M 2 🗶 F 79 10/05/1932 Maryland 28a-f shov 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director MD notified Frederick Emmitsburg 1 Yes 2 X No 5 0f. Zip Code 21727 10g. Citizen of What Country? pe 23a Funeral 7830 Friends Creek Road United States must 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. Examiner Armed Force 'natural", or ρ 1 Never Married 2 Married 1 ☐ Yes 2 XNo If Yes, Give Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify: Specify: White 3 Divorced 4 Divorced Completed Year or Dates than "natura the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Canning Factory Elementary/Secondary (0-12) College (1-4 or 5+) event, the Apple Peeler 8 and Mental Hygie is marked other Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Harold Elwood Sprenkle Margaret Elizabeth Knepper 19a. Informant's Name/Relationship (Type, Print)

Carroll R. Wetzel/Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7830 Friends Creek Rd. Emmitsburg, MD 21727 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. 20b. Place of Disposition (Name or pemetery, grematory or other place)
Riverdale Park
Crematory

22. Name and Address of Facility Gerald N. Minnich Funeral
Place St. Hagerstown, MD 21740 20a. Method of Disposition 1 🗆 Burial 2 🕱 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee m M01613 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final disease or condition Thero Sclenotic 20nset and Death ANDIOVACCULIA Physician/ Medical resulting in death) Examiner Se mentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last and burial-trar Due to (or as a consequence of): physician Physician/Medical that the death certificate be Box 68760 use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
Pregnant at time of death 5 Other (specify) in the past 12 months? Į, Month Year Day g Unknown Records, P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 11160765 The law requires 1 Yes 2 No 3 Probably 4 onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed 2 🗌 No 1 Yes 2 N 1 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No 은 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5. Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending s after death. 1 ☐ Yes 2 ☐ No □ Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined Hospital 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I 29b. Signature and title of certifier MD 00035152 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 MD KrANTZ S Centra Date filed (Mont egistrar's Signatu State Registrar

Registrar
DHMH 17 Rev 7/2009

State

3301 New Mexico Ave., N.W. #342, Washington, DC 20016

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Registrar's Signa

Mary D. Restifo,

MAR 26

31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Barbara Ennis Wainer 6:35 pm 2012 March Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Silver Spring Prince George's Renaissance Gardens - Riderwood Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Min Hours 153-28-1588 Director 1 □ M 2 🗓 F 01/18/1936 76 New Jersey show 10b. County death with the Maryland must be notified at 10c, City, Town or Location 10d. Inside City Limits Director 28a-f Prince George's Silver Spring Maryland 1 Yes 2 X No ŏ 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 3142 Gracefield Road, Apt. #T15 20904 U.S.A. "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 💢 No Black. White, etc. Completed by 1 Never Married 2 Married within 72 hours after Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give Year or Dates 3 Widowed 4 X Divorced Specify: Caucasian the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Prince George's Elementary/Secondary (0-12) College (1-4 or 5+) **5+** Teacher Community College Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ပ Theodore Ennis Pauline (Unascertainable) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 sh nt of Health au: If item 27 is Scott Marshall Wainer - Son 56 Castleton Drive, Upper Marlboro, Maryland 20774 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State ö 1 X Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) 03/26/2012 Davidsonville, Maryland Lakemont Mem. Grdns. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. neke 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Ovarian Cancer & Metastases Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Box 68760 IF FFMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Other (specify) Pregnant at time of death Month Day Year 1 ☐ Yes 2 🕱 No 9 ☐ Unknown 9 Unknown P.O. I þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗓 Unknown been si should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an or Attending Physician: The law autopsy performed this certificate 1 ☐ Yes 2 🗓 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 \square Yes 28d. Describe how injury occurred 1 X Natural 5 Pending injury 2 No within 24 hours after death

To the Funeral Director: / Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

12

3160 Gracefield Road, Silver Spring,

Maryland 20904

30. Name and address of person who completed cause of death (Item 23a) Type, Print)

CRNP.

Julaline Harding,

26 2012

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 12-02001 2012 State of Maryland / Department of Health and Mental Hygiene Michael Joseph Weems 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day March 8, 2012 0912 hrs **Medical Examiner** MICHAEL JOSEPH WEEMS 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Clinton Southern Maryland Hospital If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** oreign Min. Months Davs Hours Country) Director 62 Yrs 22/1949 2___F 1 🔀 M 213-58-8688 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b County 1 Yes 2 No Upper Marlboro or 28a-f shuv Prince Georges MD notified at once 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ā 11425 Capstan Drive items 23a 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. Funeral 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after death without of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", ur items alory or other traumatic event, the Medical Examiner must be in jury or other traumatic event, the Medical Examiner must be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 Married Yes 2 X No 4 Divorced If Yes, Give Year 1 Yes 2 No specify: Specify: Black 3 Widowed ۵ or Dates: 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Scan Int'1 College (1-4 or 5+) Elementary/Secondary (0-12) Baltimore, MD 21215-0036 Labor -Retail Warehouse Worker-Furniture 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Margaret Elizabeth Wills Be Joseph Morris Weems
19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 425 Capstan Drive, Upper Marlboro, MD 20772 Margaret E. 20a. Method of Disposition Weems / Mother 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 K Burial 2 Cremation 3 Removal from State Maryland Natl.Mem.Park 3/16/2012 | Laurel, MD 4 Denation 5 Other Specific 22. Name and Address of Facility Snowden Funeral Home 21. Sign ture of Funeral Se 246 N. Washington St., Rockville, MD 20850 Approximate Interval complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line. Death (Modical a Complications of Colon Cancer Immediate Cause (Final disease :xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): e attending physician and for use as the burial events resulting in death) Last executed sician/Medical ☐ AMENDED UNPENDED The law requires that the death certificate be Box 68760 23d. Date of deliver 23c. If yes, outcome of pregnancy IF FEMALE: 3 Ectopic pregnancy Day 23b. Was decedent pregnant in the 1 Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 햒 무 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown \$ Completed 24b. Were autopsy findings available 24a, Was an certificate has been prior to completion of cause of autopsy performed? ✓ Yes 2 No death? 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medical Hospital or Attending Physician: Division of Vital Be Other Nursing Home 5 Residence 6 Other: Hospital: 1 Inpatient 2 ✔ ER/Outpatient 3 DOA 1 🗸 Yes 2 No After this 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death within 24 hours after deam.

To the Funeral Director: A 1 🗸 Natural 1 Yes 2 No 5 Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 Could not be Suicide determined Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal

Registra DHMH 17 Rev 1/2001

OCME 2006

State

29b. Signature and title of certifier

Donna M. Vincenti, MD

31. Date filed (Month, Day, Year) **MAR 1 4 2012**

29c. License number

O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

29d Date signed (Month, Day, Year)

March 10, 2012

Assistant Medical Examiner

32. Registrar's Signature

and manner stated

30. Name and address of person who completed cause of death (Item 23a)

			Plea	se Type or	Print in	n Black	Indeli	ble In	k. Ens	ure A	All Copie	s Ar	e Legi	ible.		
		For		State o	of Maryla					and N	/lental Hy	gien	е			
		State Registrar					Certifica	te of L	Death		·	Reg. N	0.20	12	10200	
Physicia	n/	Decedent's Name									2. Date of De Month		ay	Year	3. Time of Death	
Medic	al	4a. Facility Name (if n		Christian			45 02	. T		- f D 41-	March	$\overline{}$		Year 012	11:15 A ^M	
Examin	er			ventist He		1		ckvi]	r Location o L 1e	of Death		4	Mont,		ry	
Funeral		5. Social Security Nur		6. Sex		In yrs. last birthday) If Under 1 Year If Unde				24 Hrs. Min.	8. Date of Bi				lace (State or Foreign	
Director		578-18-49 Usual Residence of		1 X M 2 □ F	85	Yr	1				June 9			Washington, D.C		
and show fat	or		10b. County		10c.	City, Town o		10020	,		10d. Inside City Limits					
Maryl. 28a-f otifiec	rect	Maryland	Montg	omery		Rockv	ille								1 🗌 Yes 2 🗶 No	
h the	al D	10e. Street and Numl	ber			10f. Zip Code						10g. C	itizen of W	hat Coun	try?	
th with ms 23 must	Funeral Director	14402 Pec	can Dr					2085					Unite	d Sta	ates	
or iter	by Fu	 Marital Status Never Marrie 	nd 2 🕱 Mari	12. Was Dece		If Yes, specify Cuban, Mexican, Puerto					ecify Yes or No- Rican, etc.)	-		- America k, White, e		
s afte ral", c Exan		3 Widowed 4		If Yes, Giv	e	944-46 1 ☐ Yes 2 X No Specify:							Specify:	Cauc	asian	
natu dical	Completed	(Spec		nt's Education st grade completed)		16a. Decedent's Usual Occupation					ina	16b.	Kind of Bu	siness/Ind	dustry	
hin 7% ne. than ie Me	om	Elementary/Secon		College (1		(Give kind of work done during most of work) life. DO NOT use retired) Technical Engineer					ing		n - 1	-1		
Hygiei ther int, th	Be	17. Father's Name (Fi	irst Middle I			Te	cnn1ca	ıı Enş			- (Final 64) 4 de		Cechn		У	
be file sintal l ked o c eve	To E			mbrose Wo	1 <i>z</i>						e (First, Middle Margar				n	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Nan				19b. N	Aailing Addre	ss (Street			al Route Numb					
d2shaaltha altha 27ie ertra		Frances V	Wolz,	Spouse							ckville					
of He of He fitem		20a. Method of Dispo		0 □ B(o. Place of D	isposition (N	ame of	re)		Date	20c. l	Location -	City or To	wn, State	
Page ment tant: I		4 Donation		3 ☐ Removal from pecify)	Ga					farch	17, 2012	Si	lver	Spri	ng, Maryland	
permit Depart Import any inj once.		21. Signature of Fund	eral Service L	icersee	MO11	.02	22. Name	and Addre	ss of Facilit	y Si	mple Tr	ibu	te			
TI = 6 0		OZa David Fataville	W	ruce		anth Danat							le, M	aryl:	and 20852	
		23a. Part 1. Enter the shock, or heart Immediate Cause (F	failure. List o	nly one cause on ea		eath. Do not	enter the me	oae ot ayın	ig, such as	cargiac o	or respiratory a	rrest,			Approximate Interval Between Onset and Death	
Physician/ Medical		disease or condition resulting in death)		a. Demen										_	Chiect and Death	
Examiner					orasa cons us Pos			mv Tı	ihe							
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Due to (or as a consequence of):														
executed an and rial-transit	Examiner	Cause. Enter Orderlying Cause (Disease or injury that initiated events Pneumonia														
e executed cian and ourial-transit																
ate brothysic	dic	Hypertension														
ertific ding p	Physician/Medical	IF FEMALE:		23c. If yes, out	come of pred	inancy										
atten aften 1 for u	iciar	23b. Was decedent p in the past 12 m 1 \(\text{Yes} \) 2 \(\)	onths?	1 🔲 Live	Birth 2 F	etal death	3 Ectopi 5 Other		Э				Mor	e of delive ith	Pry Day Year	
the de ay the achec	hys	g Unknown		g □ Unkr	nown											
that gned k	by P	Part II. Other signific	cant condition	ns contributing to d	eath but not	resulting in t	he underlyin	g cause gi	ven in Part	l.	23e. Did	tobacco	use contri	bute to th	e cause of death?	
quire; en siç ould b	ted	Respirate	ory Fa	ilure							1 🗆	Yes 2	2 □ No	3 🗌 Prob	oably 4 🗶 Unknown	
aw re las be	Completed										24a. Was	psy	р	rior to cor	osy findings available inpletion of cause of	
The cate h	Con										perf 1 \square Yes	ormed?		eath?	2 🗆 No	
ician: Sertifia ector	Be	25. Was case referred examiner?		Hospital:					ace of Dea	th (Checi	k only one)					
Phys	5	1 Yes 2 X	No	1 X 28a. Date	Inpatient 2	ER/Outp		DOA Oth	4 ∐ Nı		ome 5 Res 28d. Describe					
ath. : After e fune	Certificate:	1 X Natural 2 ☐ Accident	5 Pendin	g (Mont	th, Day, Year)			work			Zou. Describe	riow inju	iry occurre	u		
Atternation of the part of the	ərtif	3 ☐ Suicide 4 ☐ Homicide	6 Could determ	not be 28e. Place	of Injury - At		, street, fact	ory, office						r or Rural	Route Number,	
tal or rs aft al Dir led in					ng, etc. <i>(Spe</i>						City or To					
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the but	Medical	29a. Certifier 1	Certifying Medical E	Physician: To the b	est of my kno	owledge, de	ath occurred	at the time	e, date and	place, a	nd due to the o	ause(s)	and manne	er as state	ed. use(s) and manner stated	
thin 2 the lompler	Me	only one) 3 [29b. Signature and ti	_ Certify ng	Norse Practitioner	: To the best	of my knowle	edge, death o	ccurred at t	the time, da	te and pla	ace, and due to	the caus	se(s) and ma	anner as s	tated.	
25		Zab. Signature and th	The Country of	HA				9c. Licens		,			ate signed			
V-		30. Name and address	ss of parent	who completed carre	e of death //	Om 220\ /Tim	no Print\	D00	05757	4		Ma	rch 8	, 20	12	
				2401 Res				0. R	ockwi	116	Marv1	nd '	20850			
Stat		 Date filed (Month, 	, Day, Year)	3€. R	egistrar's Sig	nature 4	all		JUNE 1	,	7 10		_0000			
Registra	r	MΔI	7192	UIZ VZ		A. 18	arres .	4								

DHMH 17 Rev 06-2011

Registrar

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Blakeman,

MAR 1 6 2012

Melissa E

D 0065870

M.D., 6000 Executive Blvd., #625, N. Bethesda, MD

20852

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. = For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First_Middle_Last) 2. Date of Death 3. Time of Death 03 Physician/ Ruth Hull Walker 2012 3:35 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Care Baltimore Towson 5. Social Security Number 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Min. Hours 219-44-9288 **Director** 1 □ M 2**XX**F 66 11/20/1945 PA show at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f MD Baltimore 1 Yes XX No Cockeysville 10e. Street and Number 10f. Zip Code 'n 10g. Citizen of What Country? al Hygiene. I other than "natural", or items 23a or vent, the Medical Examiner must be r Funeral Page 1 and 2 should be filed within 72 hours after death with 11 Warwick Mill Ct. 21030 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed For Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. XX No þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes XX No Specify: If Yes, Give Year or Dates White 3 - Widowed XX Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) computer programmer/analyst Westinghouse of Health and Mental Hygie If item 27 is marked other or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Norman Milton Hull Naomi E. Shoemaker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a Elizabeth A. Hull/sister 16 Cardor Ct., Nottingham, MD 21236 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 9 Department or Important: If any injury or once. Donation 5 Other (Specify) Linwood, MD Creek Cemetery :03/27/2012 21. Signature of Funeral Service Licensee 22. Name and Address of Facilit Pritts Funeral Home and Chapel Markoll 412 Washington Road, Westminster, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician www Medical resulting in death) Due to (or as a consnce of **Examiner** Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury District for each consequence of -transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): burialattending physician for use as the buris Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death been signed by the a should be detached 1 Yes 2 19 9 Unknown Unknown by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Ves 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 : performed' Director: After this certificate 2 No Yes 2 No 1 🗌 Yes 25. Was case referred to medical filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital 2 - No 1 🗌 Yes Other: ည 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 Tes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital o within 24 hours af To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier only one Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature 29d. Date signed (Month, Day, Year) 07 Name and address of person who completed cause of death (Item 23a) (Type, Print) SH FA KUMAR N CHARLI 6701 ES RT 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 1 6 Day Month 03 201^{eg} Sharon Norma Yates 9:04 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince Georges Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Hours 1 17087 1965 578-02-8375 **Director** 46 1 M 2 X F Washington, DC 28a-f shov 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director notified 1 X Yes 2 □ No DC DC Washington, DC 10e. Street and Number 10f. Zip Code ò 10a. Citizen of What Country? ral", or items 23a o Examiner must be 1528 A Street NE 20002 United States death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc by 1 Never Married 2 X Married 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. item 27 is marked other than "natural", or other traumatic event, the Medical Examin 1 Yes 2 No If Yes, Give 3altimore, Maryland 21215-0036 Specify: Black 1 Yes 2 X No Specify: Completed 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 1 2 College (1-4 or 5+) Fiscal Specialist Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Eugene T. Allen Norma L. Yates 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eugene K. Allen brother 1314 Dunwoody Ave. Oxon Hill, MD 20745 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 70 Page 1 3/26/2012 Landover, MD permit. Page Department of Important: If any injury or once, 4 Donation 5 Other (Specify) Harmony 21. Signature of Funeral Service Licensee 22. Name and Address of Facility W. H. Bacon Funeral Home 3447 14th St., NW Washington, DC 20010 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Interval Between Onset and Death shock, or heart failure. List only one cause Immediate Cause (Final DOULdin 1 Ssive Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions of any, leading to himediate cause. Enter Underlying Cause (Disease or injury Due to for se a consecuence of. Examir the attending physician and the for use as the burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months? Month Year Pregnant at time of death Day Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has performed 2 🗌 No Yes 2 No 1 Yes To the Hospital or Attending Physician: T within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 ☐ Yes 2 ☐ No ္ဝ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at work? 1 Natural (Month, Day, Year) 5 Pending 1 Yes 2 No 2 Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier 👱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 03114

DHMH 17 Rev 06-2011

State

Registra

Dr. Eric McDonald 7503 Surratts Rd. Clinton, MD 20735

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

MAR 22 2012

D0064055

12-01942 Hugo Yupe Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ugo Yupe		State of Maryland / Department of -For State Certificate of A	H D	lealth a leath	and	Menta	al Hyg		Reg. N	10. 20	and the second	2 10	20
Physician		legistrar 1. Decedent's Name (First, Middle,Last)	_	-			2	. Date of De Month	ath Da	y Year		Time of Death	
ledical Examine		Hugo Roberto Yupe Jr.						March 7	201	2 4c. County of De		1521 hrs	
)	ŕ	Tall I dollay I tall to (ii fee montation) give		City, Town		cation of	Death			Montgomer			
	4	13220 Superior Street 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)		f Under 1		If Under	24Hrs.	8. Date of B	Birth (M	1M/DD/YYYY) 9.		ace (State or	\dashv
Funeral Director	- 1	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 214-31-8861 7. Age (In yrs. last birthday) 215-861 7. Age (In yrs. last birthday)	_		Days	Hours	Min.	Dec. 1		For	eign Countr		
	- 1-	Usual Residence of Decedent 10a State 10b County 10c City, Town or Locatio	nn.								10	d. Inside City Li	imits
w апу	ľ	Tob. Otality									1	Yes 2	No
Aaryland 28a-f show	ġ	MD Montgomery Silver S		Of Zip Co			_		10g. (Citizen of What C	ountry	?	
e Mar	Director	12043 Viers Mill Road, Apt. 201		209					U	JSA			
ith th		11. Marital Status 12. Was Decedent Ever in U.S. 13. Was		ecedent o	f Hispa			cify Yes or I		14. Race - Am		Indian, Black,	\neg
eath w	 -	1 X Never Married 2 Married Armed Forces? If Ye	es,	specify C	uban, I			ican, etc.) IVÍAN	&	White, etc			
fler d	<u>6</u>	3 Widowed 4 Divorced If Yes, Give Year 11X		es 2		specify:	Cuba	ın		Specify: Wh			
ours a		15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's during mo							16	b. Kind of Busine	ss/Indu	ustry	
6 172 h	<u> </u>	Elementary/Secondary (0-12) College (1-4 or 5+)								Restaura	n t		
within giene.	Completed	12 Chef 17. Father's Name (First, Middle, Last)		_	18	3.Mother's	Name (First, Middle	e, Maic	den Surname)			
215-0036 be filed within 7 ntal Hygiene. rked nither than ent, the Medica	Se l	Miguel Carreno				Anne	tte	Ortiz	;				
212 Suld be Ment mark	9	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing								, City or Town, St			
MD d 2 sho tth and n 27 is							oad,			01, Silve			MD
Te, Land I and I and I healt Healt I fitem		20a. Method of Disposition 20b. Place of Disposition 1 X Burial 2 Cremation 3 Removal from State	er	place)			Maı	Date ch 14	-	•			
Pages ent of int: I	1	4 Donation 5 Other Specify:	V	en Ce	met	ery		2012	S	Silver Sp	ri	ng, MD	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Impartant: If item 27 is marked other than "natural", or items 23a nr 28a-f she injury or other traumantic event, the Medical Examiner must be notified at once	1	21. Signature of Funeral Service Licensee	an	e and Ad	dress o	Colin	ins	Funer	al	Home Inc		- MD 301	001
	_	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the								lver Spi		Approximate Int	
Physician Wedital	1	failure. List only one cause on each line.						,				Between Onset Death	and and
Examiner	ĺ	Immediate Cause (Final disease or condition resulting in death) a. Gunshot wound of right forearm, ne pue to (or as a consequence of):	eci	k and n	eau				_		+		
/	-	Sequentially list conditions, b									4		
	힐	if any, leading to immediate Due to (or as a consequence of):											
2	Examiner	(Disease or injury that initiated events resulting in death) Last			_						\top		
executed an and al - transit		d									\dashv		
oe es iciar irial	dica	UNPENDED						_			\perp		
eath certificate be attending physic for use as the bu	§ [IF FEMALE: 23b. Was decedent pregnant in the 2. See See See See See See See See See Se	tal.	death	3	Ectopic	pregnar	icv		23d. Date of deli Month	very Day	y Year	r
certif	cia	past 12 months?		(Specify					- 1				
Box 68760 e death certificate be the attending physical for use as the by	Physician/Me	1 Yes 2 No 9 Unknown 9 Unknown						- D	14-1	cco use contribute	to the	a cause of death	2
that the d		Part ii. Other significant conditions contributing to death but not resulting in the u	ınd	derlying ca	use gi	ven in Par	rt I.			2 No 3			
Division of Vital Records, P.O. ral or Attending Physician: The law requires that it is after death. In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacted in by the funeral director, page 2 should be detacted.	Completed by		_					24a. W				psy findings ava	
ords tw requires as been as been as should	틆		_					au	itopsy erforme			npletion of caus	e of
Rec The la	틹							1 🗸 Ye	es 2	No 1 🗸	Yes	2 N	40
Vital Rec ysician: The his certificate director, page	8	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatient			1/	of Death (Other ₄			Re	esidence 6 🗸 0	ther: 5	Scene	
f Vi Physi er this	욘	1 Yes 2 No 28a. Date of Injury 28b. Time of I			<u>`</u>	y at Work	?	28d. Descri	be hov	w injury occurred			
ading Phyth. th. After the funeral	<u></u>	1 Natural 5 Pending Mat 7, 2012 1521 hrs		-	1 🗌 Y	es 2 🗸	No	Subject s	hot				
isic	licat	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street	et,	factory, o	ffice bu	uilding, etc	s. 1	28f. Location		eet and Number o	r Rura	I Route Number	, City
Divisior pital or Attend ours after death teral Director:	Certification:	Suicide 6 Could not be determined (Specify) Residence						13220 Sup	erior	Street, Rockvill	e, MD)	
8-27		29a. Certifier (Check only one) 2 Wedical Examiner: On the basis of examination and/or investigal	rre	d at the ti	me, da pinion.	te and pla	ice, and curred a	due to the o	ause(s	s) and manner as d place, and due	stated to the	l. cause(s)	
To the within To the comp	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigate and manner stated. 29b. Signature and title of certifier				number				29d. Date signed			
	-				O.C.N		00	ME		March 8, 201	2		
`		30. Name and address of person who completed cause of death (Item 23a)	r										
		Theodore M. King, Jr., MD. Assistant Medical Examiner	90	00 W. E	Baltim	ore Str	eet, B	altimore,	MD 2	21223			
Sta	ate	31. Date filed (Month, Day, Year) 32 Registrar's Signature	N.	1									
Regist	rar	MAR 14 2012 Genera B. 400											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death $\overset{\text{Day}}{2}\underline{012}$ Physician/ Montl Jeanne Lewis Young March 15 9:41 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery Rockville Montgomery Hospice-Casey House If Under 1 Year | If Under 24 Hrs Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 162-20-2173 Director 1 🗆 M 2 🍱 F 84 July 21, 1927 PA Usual Residence of Deceden 28a-f show aţ 10a. State 10h County 10c. City, Town or Location the Maryland 10d. Inside City Limits Director an "natural", or items 23a or 28a-f s Medical Examiner must be notified MD Montgomery Silver Spring 1 Yes 2 XXVI 10e. Street and Numbe 10f. Zip Code 10q. Citizen of What Country? 2304 Nees Lane 20905 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married 1X Yes If Yes, Give 2 No Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify 3 Widowed 4 Divorced Year or Dates. 1950-55 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) other traumatic event, the Registered Nurse Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F Morrison F. Lewis, Sr. Fernande Michaux 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 Sammie R. Young/Husband 2304 Nees Lane, Silver Spring, MD 20905 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If it any injury or o 5 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2012 Metropolitan Crematory Alexandria, VA . Signature of Funeral Service License Francis J. Collins Funeral Home Inc. M 500 University Blvd. W, Silver Spring, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Chronic Obstructive Pulmonary Disease disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine in any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence or) Mansit Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical pnic Division of Vital Records, P.O. Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Day Year 1 Yes 2 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed page certificate 1 ☐ Yes 2 🛣 No 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospice 6 Other October Hospital 1 🗌 Yes 2 🕱 No Other: |은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🔼 Natural 5 Pending injury Accident Investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 06-2011

State

6+1

Debrah Miller, CRNP

31. Date filed (Month, Day, Year,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's

R143201

1355 Piccard Drive, #100, Rockville, MD 20850

12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State AMEND#7+8perFH, 3/22/2012, BM:, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 03/08/2012 GLADYS LOUISE YOUNG 12:35 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth 1932 **Funeral** Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign NJ Country) 1 □ M 2 🕅 F Months (Month, Day 1967) Director 142-24-5786 Jsual Residence of Decedent ed other than "natural", or items 23a or 28a-f shov event, the Medical Ex-miner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Montgomery Silver Spring Oe. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 107 Hamilton Avenue 20901 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 1. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married <u>≨</u> within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No If Yes, Give Specify. Specify: Black 3X Widowed 4 □ Divorced Completed Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should e filed within 72 Department of Health and Mental Hyg nene. Important: If item 27 is man ed outher than 'any injury or other traumati event, the Melany injury or other traumati event, the Mel Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker yrs Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John Holmes Catherine Hawkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) April Young/daughter Vodroffslund 7, 1927 Frederiksberg, Denmark 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Memorial Pk | 03/22/2012 | Rockville, MD 21. Signature Funeral Service Licensee 22. Name and Address of Facility Snowden Funeral Home 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of) attending physician for use as the burid Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death Other (specify) Month Dav Year 1 Yes 2 No 9 Unknown ed by the a detached f 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 this certificate has autopsy performed 2 🗆 No 1 Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2X No 1 Yes ဂ္ 1 X Inpatient 2 - ER/Outpatient 3 - DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 Natural 5 Pending ithin 24 hours after death.

the Funeral Director: After ompleted filled in by the fun 2 Accident
3 Suicide 1 Yes 2 🗌 No Investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical 1 🗴 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 🗆 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the To the Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar

(10

Box 68760

P.O.

Records,

Division of Vital

D60100

831 University Blvd. E, #27, Silver Spring, MD 20903

03/08/2012

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Tahmina Khanam Ahmed, MD

31. Date filed (Month, Day, Year)
MAR 16 2012

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND TTEM#20b, perFH, G926, 4/9/2012, WS
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ P_M 10. March 1:00 Vance D. Zook Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Larkin Chase Nursing Home Bowie Social Security Numbe If Under 1 Year If Under 24 Hrs Months Days Hours Min. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 183-12-4989 90 **Director** 1**X** M 2 □ F 3/23/1921 Pennsylvania Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland 10a. State items 23a or 28a-f sho ner must be notified at Director Maryland Prince George's 1 Xes 2 No Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 15708 PineCroft Lane 20716 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Bace - American Indian 11. Marital Status Examiner d Forces? Yes 2 \(No \) Army Black, White, etc. ò þ 1 Never Married 2XX Married XXYes Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates. 1 Yes 2XXNo Specify: "natural", 3 Divorced 4 Divorced MMII Completed ige 1 and 2 should be filed within 72 hour nt of Health and Mental Hygiene.

E: If item 27 is marked other than "natur or other traumatic event, the Medical I. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired)

Professional Elementary/Secondary (0-12) College (1-4 or 5+) and Surveyor Dept.Of Interior Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Unknown Cordula Zook 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Florence E.Zook -wife 15708 PineCroft Lane, Bowie, Md. 20716 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State /15/2012 cemetery, crematory or other place) 3/ Ressurection Cemetery 3/ Xurial 2 Cremation 3 Removal from State . Page 1 2012 Department of Important: If any injury or Clinton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Robert E. Evans Funeral Home Signators of Funeral Service Licenses 1-Kon YOL 16000 Annapolis Road, Bowie, Md. 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Dementia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the ass IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) for in the past 12 months? Day Month Year Pregnant at time of death Yes 2 No be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes XX No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed page 2 Yes 2X No 25. Was case referred to medica 26. Place of Death (Check only one) director, To Be examiner?
1 Yes 2 X XNo Other: XX Nursing Home 5 - Residence 6 - Other (Specify, 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred 1XXNatural 5 Pending after death. 2 🗆 No М 1 Tes Accident
Suicide Investigation filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number. 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined City or Town, State) 24 hours Medical 1 ី🌡 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Funer completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State

Ajayi, M.D. 31. Date filed (Month 4 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

6201 Greenbelt Road, St. M18, College Park, Md. 20740

Registrar

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

D45217

29d. Date signed (Month. Dav. Year)

3/12/12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ narch Medical Acility Name (if not institution ive street and number) or Location of Death Examiner 4c. County of Death 8. Date of Zirth . Age (In y . last birthday) If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** Country) MD 215-24-0597 Hours Dec. 2, 1929 82 Director 1 □ M 2 ቖ F Usual Residence of Decedent 28a-f show er than "natural", or items 23a or 28a-f sho , the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Baltimore 1 Yes 2 X No 10e. Street and Numbe 10g. Citizen of What Country? 10f. Zip Code 21224 Funeral 7306 Bridgewood Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 ☐ Xio Black White etc. þ 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White If Yes Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry 2 should be filed within 72 l h and Mental Hygiene. 7 is marked other than "n Account Manager Elementary/Secondary (0-12) 12th College (1-4 or 5+) Food Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Mary Catherine Beil 1 and 2 should be first Health and Mental Fitem 27 is marked မ George Hohman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
8 3 0 5 Glen Road Baltimore MD 21234 8305 Glen Road permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other ti Kim Andreasik /daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 😾 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) SacredHeartofJesus 4/4/12 Baltimore MD 21. Signature of Fundal Service 22. Name and Address of Facility 300 MAce Ave. Balto. MD Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of): attending physician a for use as the burialresulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death detached the 9 Unknown P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sign Division of Vital Records, 1 Tes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital မှ After this c funeral dir Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural Accident 5 Pending injury eral Director: A filled in by the fi Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier (Check Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. oply of and t Signate

20%

State Registrar

DHMH 17 Rev 06-2011

32. Registrar's Spinature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 8:25 <u>Pinkie Louise Allen</u> March Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 4007 20th Place Temple Hills Prince Georges 8. Date of Birth 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Months Days 260-98-1129 Hours **Director** 1 🗆 M 2 🔀 F 69 12/28/1942 Texas 28a-f shov 10c. City, Town or Location aţ 10a. State 10d. Inside City Limits with the Maryland Director notified Temple Hills MD Prince Georges Yes 2 No 10e. Street and Numbe 10f. Zip Code ō 10g. Citizen of What Country? must be Funeral 23a 4007 20th Place 20748 USA death Was Deced Armed Forces? 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Medical Examiner Black, White, etc. 5 þ 1 Never Married 2 Married filed within 72 hours after Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. 3[¥] Widowed 4 □ Divorced Specify: Black "natural" Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the 4 censed Practical Nurse <u>Private Industry</u> event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I permit. Page 1 and 2 should be.
Department of Health and Merrinportant: If item 27 is any injury or off မ Rossie Spearman Grace Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4007 20th Place Temple Hills, MD 20748 Steven Allen/Son 20a. Method of Disposition
1 → Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 3/27/2012 Suitland, MD Lincoln Memorial 4 Donation 5 Other (Specify) 21 Signature Funeral Service Lice 22. Name and Address of Facility Latimore Funeral Services Baltimore, MD 21224 2818 E. Baltimore St. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final . Set Year s Physician/ Breast Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examin Cause (Disease or injury that initiated events resulting in death) Last nding physician and use as the burial-tran Due to (or as a consequence of) Physician/Medical The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death signed by the ard be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>항</u> Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 page 2 has this certificate Division of Vital • Hospital or Attending Physician: 24 hours after death. • Funeral Director: After this certific filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 \square Nursing Home 5 \boxtimes Residence 6 \square Other (Specify) 1 Yes 2 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred (Month, Day, Year) 5 Pending **∑**Matural Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the past of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) fell en 3/23/2012 D64234

DHMH 17 Rev 06-2011

State Registrar 8926 Woodyard Rd. Suite 101

Clinton,MD 20735

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Nicholas A. DeMonaco, MD

31. Date Fled (Month, Day, Year, 0 3 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 2012 Month Carl Antkowiak April 6:00 p^M Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Baltimore 7261 Conley Street Dundalk 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthdav) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Min Hours 216-24-9256 **Director** 1 🕱 M 2 🗆 F 83 Yrs Maryland March 8,1929 Usual Residence of Deced 28a-f show 10a, State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Md. Baltimore Dundalk 1 Yes 2 X No 10e. Street and Number 10f, Zip Code items 23a or ner must be n 10g. Citizen of What Country? Funeral 7261 Conley Street 21224 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. ō þ 1 Never Married 2 Married Yes 2 X No 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🙀 No Specify: White Specify: "natural", Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 years Shipping Supervisor American Can Company Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be file h and Mental H 7 is marked of ဂ္ Joseph Antkowiak Ida Nitka other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. Cornelia Antkowiak Wife 7261 Conley Street, Dundalk, Md. 21224 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland St. Stanislaus Cem. 2012 4 Donation 5 Other (Specify) Signature of Luneral Service Licensee 22. Name and Address of Facility
Connelly Funeral Home of Dundalk, P.A. Part 1. Enter the disease or complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ DHENWOHIA disease or condition resulting in death) Medical Examiner energy' Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury and I-transit Exami that initiated events resulting in death) Last Due to (or as a consequence of) burial-Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Day Pregnant at time of death 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 5 Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a, Was an autonsy 2 🗌 No Yes 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) Hospital: Other: 2 **N**o 1 Yes ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🗶 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) e Hospital or Attending Pl 124 hours after death. e Funeral Director: After the oletely filled in by the funera 28b. Time of 28c. Injury at 28d. Describe how injury occurred iniury work?
1 Yes 2 No 1 🚺 Natural 5 Pending Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State To the Hospital within 24 hours a To the Funeral C 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. соmpletely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 00043680 on who completed cause of death (Item 23a) (Type, Print)

Macha Lord Center Tower #5100 Registrar

68760

Box (

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	For State of Maryland , State Registrar		tificate of E			Reg. No. 20	12 10211		
	Physicia		1. Decedent's Name (First, Middle, Last) ROBERT CHARLES		ANDREWS		2. Date of Dea Month MARCH		3. Time of Death		
	Medic Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or	Location of Dea		4c. County of			
			31 HERRINGTON DRIVE		UPPER N			PRINCE GEORGE'S			
M.	Funeral Director		5. Social Security Number 428-56-3336 Usual Residence of Decedent	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi		13 1936	B. Birthplace (State or Foreign Country) MISSISSIPPI		
	yland f show ed at	tor	10a. State 10b. County 10c. City, To	own or Loc	ation				10d. Inside City Limits		
	28a-	Director		PER M	ARLBORO				1 XYes 2 □ No		
	with the	Funeral D	10e. Street and Number 31 HERRINGTON DRIVE		10f. Zip Code	20774		10g. Citizen of What USA	at Country?		
3036	within 72 hours after death with the Maryland grene. grene. er than "natural", or items 23a or 28a-f show, the Medical Examiner must be notified at	Completed by Fun	11. Marital Status 1 Never Married	NES	/as Decedent of His Yes, specify Cubar ☐ Yes 2X No		(Specify Yes or No- erto Rican, etc.)		American Indian, White, etc. BLACK		
21215-0036	iin 72 hoi ie. han "nat e Medica	omple	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	(Give k	ent's Usual Occupa ind of work done d ONOT use retired)		vorking	16b. Kind of Busi	ness/Industry		
	iled with Hygien o ther t i vent, the	Be C	12TH	SE	CURITY			PRIVAT	TE		
Maryland	~ σ σ π	To B	17. Father's Name (First, Middle, Last) ROBERT MCKINNLEY ANDREWS			18. Mother's N	Maiden Surname) . EY				
a _Z	should and Mr is mar aumati		19a. Informant's Name/Relationship (Type, Print)	19b. Mailing	g Address (Street a	nd Number or F	Rural Route Numbe	r, City or Town, Stat	e, Zip Code)		
	1 and 2 should be of Health and Ment if item 27 is marked other traumatic		KAREN ANDREWS/WIFE	31 H	ERRINGTON	DR. U	PPER MARL	BORO, MARY	LAND 20774		
Baltımore,	의 그 프 급			etery, crem	sition (Name of eatory or other place		Date	20c. Location - Ci	ty or Town, State		
ᆵ	t. Pagartment rtant: rjury c				E CREMATO		31/2012		LE, MARYLAND		
Ba	permit. Pag Departmen Important: any injury o		21. Signature of Fyneral Service Licensee Cornelius						ERAL HOME, INC. RYLAND 20785		
ı			23a. Part 1. Enter the disease, or complications that caused the death. D shock, or heart failure. List only one cause on each line. Immediate Cause (Final	o not enter	r the mode of dying	, such as cardi	ac or respiratory arr	est,	Approximate Interval Between Onset and Death		
	Ph		disease or condition resulting in death) a. Due to (or as a consequence)	IAC A	RREST						
	Examiner		нург	RTENS	SION						
	_ =	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying						73		
	executed an and rial-transi	xan	Cause (Disease or injury that initiated events c. Due to (or as a consequence of the consequence)	ce off:							
		edical Examiner	resulting in death) Last	00 017.							
09/	icate be g physici s the bu		d								
Box 68	requires that the death certific been signed by the attending should be detached for use a	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal de	eath 3 🗌	Ectopic pregnance Other (specify)	4		23d. Date of Month			
O.	that the d ned by the e detacher	hys	g ☐ Unknown								
J.	requires that been signed should be de	þ	Part II. Other significant conditions contributing to death but not resulting	ng in the ur	nderlying cause giv	en in Part I.			te to the cause of death?		
Vital Records,	The law req	Completed					24a. Was autop	prior prior dea	re autopsy findings available or to completion of cause of th?		
ř =	ificate or, pa		25. Was case referred to medical		26 Dia	ce of Death (C/		2 X No 1	Yes 2 No		
VIT3	ysicia s cert direct	To Be	examiner? 1 🗷 Yes 2 🗆 No Hospital: 1 🗀 Inpatient 2 🗆 ER/	/Outpatient	Othe	r.	Home 5 X Resid	lence 6 \(\text{Other } \)	Specify		
n of	nding Phy th. : After thi e funeral			b. Time of injury	28c. Injury work	at		ow injury occurred	5500ny)		
Division of	or Atter after dea Director I in by th	Certificate:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)								
ב	To the Hospital or Attending Physician: The law within 24 bours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	edical	29a. Certifier 1 X Certifying Physician: To the best of my knowledg (Check 2 Medical Examiner: On the basis of examination an	d/or investi	gation, in my opinio	 death occurre 	ed at the time, date a	nd place, and due to	the cause(s) and manner stated.		
	To the within To the compl.	Σ	only one) 3 🗓 Ceftifying Nurse Practitioner: To the best of my k 29b. Signature and title of certifier	nowledge,	29c. License			he cause(s) and man 29d. Date signed (A			
	(~		N VOCA NO			7A42880)	MARCH 3	30, 2012		
	2h.		30. Name and address of person who completed cause of death (Item 23: J. MALOUF MD 1050 W PERIMETOR RO			B, MARY	YLAND 207	62			
	Stat Registra	e	31. Date filed (Month Cay Year) 2012 2. Registrar's Signature	bar	w						

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of M	1arylan		artment of			ental Hy	giene		0 . 0 0 1 0	
			Registrar			Cer	tificate of	Death			Reg. No	201	2 10212	
Н	Physicia	ın/	Decedent's Name (First, Middle,	,						2. Date of Dea Month		y Year	3. Time of Death	
~	Medic	al	Akbar Aslinejac							March		2012 Year	10:40AM M	
	Examin	ier					4b. City, Town, or Location of Death			4c. County of D				
	Funeral		12004 Milestone 5. Social Security Number			ast birthday)	German If Under 1 Year		er 24 Hrs.	8. Date of Birt		lontgom 9. Bi	ery rthplace (State or Foreign	
	Director		578-35-9884	1 X M 2 □ F		Yrs.	Months Days	Hours	Min.	(Month, Day	y, Year)		ountry)	
	d d		Usual Residence of Decedent 10a, State 10b, County		64		<u> </u>			February	25,	1948 I:	ran	
	rylan I-f sh ied a	cto			10c. City	y, Town or Lo	cation						10d. Inside City Limits	
	r 28a notif	Dire	Maryland Montg	omery	Ge	rmanto	wn 10f. Zip Code				10 01		1 ☐ Yes 2 🔀 No	
	vith th	ra		M T			20876			1	10g. Citizen of What Country? United States			
	ems er mu	Funeral Director	12004 Milestone	12. Was Decedent	Ever in U.S	S. 13. V	Vas Decedent of H	lispanic Or	rigin? (Spec	ify Yes or No-		14. Race - Am		
36	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 🛣 Marrie 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	No	l I	Yes, specify Cub	an, Mexica	an, Puerto R	lican, etc.)		Black, Whi	te, etc.	
9	hours natura ical E	Completed	15. Decedent'	Year or Dates.		16a, Deced	lent's Usual Occur	ation			165 Ki	Wh ind of Business	ite	
215	in 72 e. nan "r	mp	(Specify only highest Elementary/Secondary (0-12)	t grade completed) College (1-4 or	5+)	(Give I	kind of work done O NOT use retired,	during mos	st of working	g	TOD. IN	ind or business	of industry	
21	withi		and the state of t	5+	01/	Engi	neer				Co	nstruci	tion	
pui	filed tal Hy ed ott	To Be	17. Father's Name (First, Middle, Las	st)				18. Moth	her's Name	(First, Middle,	Maiden S	Surname)		
yla	should be file and Mental F is marked o raumatic eve		Ismail Aslineja						Taheri					
Ma	12 sho Ilth and 27 is r	- 8	19a. Informant's Name/Relationship				g Address (Street							
ē,	and Heal tem 2		Nastaran Asline 20a. Method of Disposition	<u>:jad/ Daugh</u>			Town Community Sition (Name of	nons L		German		n, Mary. ecation - City o	Land 20874	
mo	Page Thent of ant; If it ury or		1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		e C	emetery, cren	natory or other pla	· .		i1		-		
Baltimore, Maryland 21215-0036	permit. Page 1:8 Department of H Important: If ite any injury or ot		21. Signature of F / al Service Lic		Pari		emorialP . Name and Addre				Pump	hrey F	Maryland uneral Home/	
<u>m</u>	B E E	-	1	int	M003	35	Rockvill Rockvill	e, li	nc. 30 arylar	$\frac{10}{10}$ West	0 ^M 28	tgomer 05	uneral Home/ y Avenue	
П		1	23a. Part 1. Enter the disease, or conshock, or heart failure. List only	omplications that cause by one cause on each lin	d the death ie.	h. Do not ente	r the mode of dyir	ng, such as	s cardiac or	respiratory arr	rest,		Approximate Interval Between	
	hysician/	W 3	Immediate Cause (Final disease or condition	_ a. Aspira	tion	Pneumo	nia						Onset and Death	
7	Medical Examiner		resulting in death)	Due to (or as	a consequ	ence of):								
		Jer	Sequentially list conditions, cause. Enter Underlying	b. Corona	ry Ar	tery D	isease							
	d d ansit	Examiner	Cause (Disease or injury		pertension									
	exectan an an irial-tr		that initiated events resulting in death) Last	a consequ										
09	cate be executed physician and s the burial-transit	edical		L _{d.} Parkinson's Disease										
Box 68760	artifica ding p	/Me	IF FEMALE:	22a Huga autaoms	of aroma									
X	ath ce attend for us	sian	23b. Was decedent pregnant in the past 12 months?		2 Feta	I death 3	Ectopic pregnan	СУ			1 2	23d. Date of de Month	elivery Day Year	
m	hat the death certific ed by the attending p detached for use as	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant a 9 ☐ Unknown	at time of q	ieat⊓ 5 ∟	Other (specify) _					World	Day 10ai	
P.0	that the	by Pł	Part II. Other significant conditions	s contributing to death I	but not resu	ulting in the u	nderlying cause gi	ven in Part	: I.	23e. Did to	bacco u	se contribute to	the cause of death?	
S,	requires that been signed to should be det	ed b	Cerebrovascu	lar Acciden	t					1 🗆 ነ	res 2	□ No 3 □ F	Probably 4 🕅 Unknown	
orc	w req s bee 2 sho	plet	Dysphasia							24a. Was a			itopsy findings available	
Rec	rsician: The law is certificate has t	Completed	•							autop perfor 1 \square Yes	rmed?	death?	completion of cause of	
<u>e</u>	sian: ertifica ector,	Be (25. Was case referred to medical examiner?				26. P	ace of Dea	ath <i>(Check c</i>		2 25 140		3 2 2 110	
₹	Physic this ce	ပ	1 Yes 2 No			ER/Outpatien	t 3 🗆 DOA Oth	er: 4 🗆 N	lursing Hom	e 5 🛚 Resid	ence 6	Other (Spec	cify)	
Division of Vital Records, P.O.	ding Physician: The la th. After this certificate ha funeral director, page	Certificate:	27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident Investigat	28a. Date of inju (Month, Da	ury ny, Year)	28b. Time of injury	28c. Injur work M 1			ld. Describe h	ow injury	occurred		
sio	Atten r deat cctor;	ij	2 Accident Investigat 3 Suicide 6 Could no 4 Homicide determine	ot be	ury - At hor	me, farm, stre		res 2 L		Rf. Location (S	treet and	Number or Ri	ıral Route Number,	
ĭ	al or safte		4 🗆 Homicide determine	building, et	c. (Specify))	, ,			City or Tow				
_	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier 1 X Certifying P (Check 2 Medical Exa	hysician: To the best of	my knowle	edge, death o	ccurred at the time	e, date and	d place, and	due to the ca	use(s) an	id manner as s	tated. cause(s) and manner stated.	
	the thin 24 the F	Me	only one) 3 \(\subseteq\) Certifying N	lurse Practitioner: To th	ne best of m	ny knowledge,	death occurred at	he time, da	ate and place	e, and due to th	ne cause(s) and manner a	as stated.	
	2 ≥ 2 0		29b. Signature and title of certifier	intimo			29c. Licens			1		e signed (Mont		
	Kar				111 (1:	00-1 0	D411	62			Mar	ch 30,	2012	
) ()		30. Name and address of person wh	· ·	,	, , , , .	,)./	1 1 0	007/			
	Stat	e	Vinu Ganti, M.D. 31. Date filed (Month, Day, Year)	32. Registra	ar's Signati	nte T T	, German	LOWn	<u> riary</u>	land 2	00/4	•		
	Registra		APR 0 3 201	32. Registra	p.	gara								

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 30^{ay} Joseph Matthew Aversa 2012 18:20pm March Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospice Dove House Westminster Carroll . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) Months (Month, Day, Year) 217-20-8388 Director 84 1 M 2 □ F 5-26-1927 MD Usual Residence of Decedent 28a-f shov 10b. County 10a. State with the Maryland must be notified at 10c. City, Town or Location Director 10d. Inside City Limits MD Carroll Westminster 1 Yes X No 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23aFuneral 631 Meadow Branch Rd. 21158 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. "natural", or Completed by 1 Never Married 2 Married X Yes permit. Page 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify 3 X Widowed 4 ☐ Divorced Specify: White Year or Dates. Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) the 10 Huckster Produce Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Gaetano Aversa Adelina Fertita 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William G. Aversa-son Western Chapel Rd., Westminster, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Kurial 2 Cremation 3 Removal from State injury (4 Donation 5 Other (Specify) Lake View Mem 4/3/12 Sykesville, MD any in Signature of Funeral Service Licensee 22. Name and Address of Facility Fletcher Funeral Home 254 E. Main St., Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Onset and Death -umon Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Due to (or as a consequence of): burial-t resulting in death) Last physician Physician/Medical Attending Physician: The law requires that the death certificate be Box 68760 as the IF FEMALE: use yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy P in the past 12 months? Month Pregnant at time of death Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ 9 ☐ Unknown g Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2. No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy pertormed? this certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) DOVE HOUSE 1 Tyes 2. No ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 24 hours after death.

Funeral Director: After 1 Natural 5 Pending work?
1 Yes 2 No Accident Investigation the Suicide 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, determined 0 City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the within 2 To the F only one) 29b. Signature and til 29d. Date signed (Month, Day, Year) mi 10059552 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7WA POULE RO WESTMINSTER MU 21150 MAURINA 31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

State

Registrar

3 2012

12-02497	
Vicki Barth	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Vicki Barth		- For State	Stat	e of Maryla	•	artment o		nd Menta	l Hygie	ne Reg.	No. 2 () 1 2	2 1021
Physician/ Medical Examine	1	Decedent's Name (Fire	st, Middle, L		ci L. Bar	th			Mo	ite of Death	av Yea		3. Time of Death 2005 hrs
	4	ta. Facility Name (if not in Baltimore Wash					4b. City, Town, Glen Burn	or Location of D	eath		4c. County of		
Funeral Director		5. Social Security Number		Sex	7. Age (In yrs. I	last birthday) 51 Yrs		ear If Under 2 ays Hours	Min	Pate of Birth(Foreign	place (State or htry)Louisiana
т аву	-	Jsual Residence of Deca 10a. State 10b.	edent		10c. City	, Town or Locat	1			-		1	0d. Inside City Limits
the Maryland n or 28a-f sho tified at once.	-	Maryland A	nne Ar	undel Sixth Stre	ept .		10f. Zip Code	Pasader 21122	na.	10g.	Citizen of Wh	at Countr	1 Yes 2 X No
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director		11. Marital Status 1 Never Married 2		12. Was Dec	edent Ever in U					Specify Yes or No- 14. Race - A			an Indian, Black,
"natural", o Examiner n	\$ _	Widowed 4 15. Decedent's Education Elementary/Secondary	on (Specify	ed If Yes, Give Yea or Dates: only highest grad	r de completed)	16a. Deceden		lo s <i>pecify:</i> pation (Give kind fe. DO NOT use					
21215-0036 vaid be filed within 72 hour Mental Hygiene. marked other than "astu c event, the Medical Exam To Be Completed	-	12 7. Father's Name (First,		O st)		Но	memaker ———				HOUS den Surname)	sewif	e
2121. 2121. d Mental H is marked fit event, f	3	9a. Informant's Name/R	elationship	Jude L	andry ————————————————————————————————————	19b. Mailing	Address (Str	Nan eet and Number	Cy YOU	_	r, City or Town	ı, State, Z	Zip Code)
, MD and 2 sho calth and com 27 is raumati	L	Timothy R. B		(H	usband)		Sixth Str	eet, Pasa		Marylano			
Baltimore, permit. Pages 1 ar Department of Her Important: If ite	Ų.	1 X Burial 2 Cr	emation :	fy:	om State Gle	crematory or othern Haven N	er place) [emori al]	Park 4	/2/201	2	Glen Burn	nie, N	Maryland
Ball permit Depart Impor		1. Signature of Funeral	2		MOO1	75 32	04 Mounta	ss of Facility	Pasade	na, Mary	yland 2	1122	ome, P.A.
Physician /Medical Examiner		failure. List only one cause on each line. Immediate Cause (Final disease a. Pulmonary Thromboembolism									Approximate Interval Between Onset and Death		
		Sequentially list condition	ns,	b	consequence o							_	
e executed cian and rial - transit dical Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of):							-	-				
be executed initial - transit dical Ex	\vdash	X UNPENDED		d AMENDED 2	3a,pt.I	I,27,pe	r me,g9	28 6-8-	-12 st	n			
tox 68760 leath certificate I attending physi for use as the bu	IF 23	FFEMALE: Bb. Was decedent pregn past 12 months? Yes 2 No 9	ant in the	1 Live bi	ant at time of de	2 Fe	al death 3 ner (Specify)	Ectopic pre	egnancy		23d. Date of o	lelivery Day	y Year
, P.O. E res that the d signed by the be detached d by Phy		art II. Other significant Raynaud [†] s		-	death but not re			•		_	cco use contrib	_	e cause of death?
Records, P.(The law requires tha ficate has been signed page 2 should be det Completed by									- [4a. Was an autopsy performed Yes 2	pr d? de		psy findings available inpletion of cause of
Vital Rec ysician: The his certificate director, page o Be Con	2	5. Was case referred to examiner?		Hospital: 1	npatient 2	ER/Outpatient		Other No	eck only on arsing Hom		sidence 6	Other:	
on of Vi ending Physi ath. or: After this he funeral dii tion: To	2	1 Yes 2 1 7. Manner of Death 1 X Natural 5	Pending		of Injury Day,Year)	28b. Time of Ir		ury at Work? Yes 2 No	28d. E		injury occurre	d	
Division of oppiration of oppiration of Attending hours after death. Bueral Director: After y filled in by the fune of fune of the fune of the oppiration o		Accident Suicide 6 Homicide	Investiga Could no determin	ot be 28e. Place	of Injury - At ho	ome, farm, stree	t, factory, office	building, etc.		ocation (Stree Town, State		or Rural	Route Number, City
DIVI To the Hospital or within 24 hours after To the Funeral Dir completely filled in Medical Certiff				cian: To the best er:On the basis o and manner st	f examination a	-							ause(s)
N S H S H	2	9b Signature and title of	certifier	16 7/e	elm	086		se number	_	- 1	d. Date signed larch 29, 2		, Day,Year)
9	3	0. Name and address of Victor Weedn MI		completed caus Assistant Med			. Baltimore	Street, Balti	more, M	D 21223			
State Registrar		APR 0 3 2012	(Year)	32. Re	gistrar's Signatu	re		-					7,1,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Helen Bagley Adril 1, 2012 12:50 рм Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Towson Baltimore Gilchrist Center If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Country) Maryland **Funeral** Jul 3, 1925 Hours 212-20-5930 Director 86 1 □ M 2 🔭 F Yrs show 10a, State Examiner must be notified at Director 10c. City, Town or Location 10d. Inside City Limits 28a-f MD Baltimore Timonium 1 Yes 2 X No 10e. Street and Number ö 10f. Zip Code 10g, Citizen of What Country? items 23a Funeral 12261 Roundwood Rd., Apt, 1416 21093 U.S.A. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. "natural", or Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after 1 Yes 2 No Specify: If Yes, Give 3 Widowed 4 Divorced Specify: White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Meones. Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Fiedler Nicholas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John C. Bagley-son 906 Morris Ave., Lutherville. MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Hilltop Serv Corp 4/2/12 Towson, MD 21. Signature of Funeral S ce Licensee William G. Dau 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Ph, ician Medical Onset and Death Due to (or as a consequence of) BREASTCANCOR TASTATIC MORIC resulting in death) Examiner Sequentially list conditions, Examine Dow to Ciritis a densequence of cause. Enter Underlying Cause (Disease or injury burial-tra that initiated events Due to (or as a consequence of) resulting in death) Last attending physiciar Physician/Medical or Attending Physician: The law requires that the death certificate be P.O. Box 68760 as the IF FEMALE: nse 23b. Was decedent pregpant 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) Month Day Year the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by YPERTENSION Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown peen HROWIC OBSTRUCTIVE PULMONARY DISCASE 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has page 2 within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, bao 1 Ves 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 - No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 O 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending iniury Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) W

Registrar DHMH 17 Rev 06-2011

State

30 Name au

^{Year)} 2012

6701 NapTH ChAR

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Marylai		artment of He tificate of De		, ,	ene g. No. 2 ()	12	1021	6
	Physicia	n/	1. Decedent's Name (First, Middle, Last,					2. Date of Death		Vasy	3. Time of Death	3
	Medic	al	VIR GINIA 4a. Facility Name (if not institution, give s	BECK		4b. City, Town, or L	time of Dooth	Hyril	2 201	12	94cAN	1
: مر	Examin	er	Northwest Hospita				lstown		4c. County of Balt	timor	:e	
	Funeral		Social Security Number 6. Sex	7. Age (In yrs.	.,	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	'ear)	9. Birthpla	ace (State or Foreigi	n
	Director		182-12-9690 1 Dusual Residence of Decedent	л 2X г 92	Yrs.			Aug. 28	,1919 I	enns?	sylvania	
	yland f shov ed at	tor	10a. State 10b. County	10c. C	ity, Town or Lo	cation				10	d. Inside City Limits	
	ne Mar nr 28a notifi	Dire	Maryland Baltimo	re I	<u>Baltimo</u>	re 10f. Zip Code		10	g. Citizen of Wh	ant Count	1 ☐ Yes 2 💢 N	0
	with the 23a cust be	Funeral Director	6515 Hazelwood Co	urt		21237			U.S.A		y:	
	death items ner m		11. Marital Status	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☒ No	.S. 13. V	Vas Decedent of Hisp f Yes, specify Cuban,	panic Origin? (Spe Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race			_
036	s after ral", or Exami	ed by	1 ☐ Never Married 2 ☐ Married 3 🕅 Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔏 No If Yes, Give Year or Dates.	1	☐ Yes 2X No	Specify:		Specify: White			
2-Q	'2 hour "natur edical	plete	15. Decedent's Ed (Specify only highest grad	ucation	16a. Deced	lent's Usual Occupati kind of work done dui	ion rina most of worki	na 1	6b. Kind of Bus			_
Maryland 21215-0036	ithin 7 ene. r than the Me	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do	o NOT use retired) Homemaker			Own Ho	me		
מ	be filed within 72 hours after death with the Maryland antal Hygiene. Ked other than "natural", or items 23a or 28a-f show co other than "natural", or items 23a or 28a-f show cevent, the Medical Examiner must be notified at	Be	17. Father's Name (First, Middle, Last)					e (First, Middle, Ma		iiie		_
ylaı	0 E 2 U	욘	John	William	Hels]	Ley	De	lpha .	Vince	nt		_
Mar	2 sh thar thar 27 is trau		19a. Informant's Name/Relationship (Typ		T.	g Address (Street an		, ·		, ,	,	,
re,	and Hea em ther		Adele F. Di Nata. 20a. Method of Disposition	20b.	Place of Dispo	Wintergre sition (Name of natory or other place)			Oc. Location - C	_		_
Baltimore,	. Page 1 tment of tant: If it jury or o		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	removal nom state	ardens o	of Faith	4-6-2		Baltimor		laryland	
Ball	permit. Pag Department Important: any injury o		21. Signal are of Europeal & Mice Nice se	e ha au	22	. Name and Address 1050 York		ck Towsor owson, Ma		al Ho 212		
H		П	23a. Part 1. Enter the disease, or composhock, or heart failure. List only on	ications that caused the dea	ath. Do not ente	er the mode of dying,					Approximate Interval Between	
- 1	Medical	pl 1	Immediate Cause (Final disease or condition resulting in death)	a. Pheum Je to (or as a consec	onia	-				-	Onset and Death	
	Examiner			A 12 va c	quence of):	Lic C	adiev.	ASCWO	a dese	00	0	
	7 t	Examiner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying	Due to (or as a consec				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				
	be executed sician and burial-transi	Exan	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a consec	quence of):	· · · · · · · · · · · · · · · · · · ·				+		_
0	e be ex ysician e buris	edical		d								
09/89	certificate nding physuse as the	/Med	IF FEMALE:						T			_
Box	death ce he attend ied for us	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	3c. If yes, outcome of pregr 1 ☐ Live Birth 2 ☐ Fe 4 ☐ Pregnant at time of	tal death 3 🗔	Ectopic pregnancy Other (specify)			23d. Date Mont		ry Day Year	
O. B	the deby the tachec	hysi	g 🗆 Unknown	g 🗌 Unknown								
J.	law requires that the death certificate be executed as been signed by the attending physician and a 2 should be detached for use as the burial-transit	by	Part II. Other significant conditions co	ntributing to death but not re	esulting in the u	nderlying cause give	n in Part I.				e cause of death? ably 4 Unknow	/n
Records,	aw requas beer 2 shou	Completed						24a. Was an autopsy		ere autops	sy findings available)
								perform	ed? de	eath?		_
/Ita	rsician s certifi directo	To Be	25. Was case referred to medical examiner? 1 Yes No	lospital:	T EB/Outpation	Other	be of Death (Check	only one) me 5 🗀 Residen	as & Youk	COS.	0100	
ot	or Atter ding Physician: The after death. Director After this certificate I ir by the funeral director, pag		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury			28d. Describe how	7	өреспу		_
S S	tter dir death. stor Af y the fu	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be			M 1 □ Y	es 2 🗆 No	001.1				_
Division of Vital	al or Atteriors after decth		4 Homicide determined	28e. Place of Injury - At Inbuilding, etc. (Speci		еет, тастогу, опісе		28f. Location (Stre City or Town,		or Hural F	Route Number,	
	To the Hospital or within 24 hours afti To the Funeral Dil completely filled in	Medical	(Check 2 Medical Examir	ician: To the best of my knowner: On the basis of examination	on and/or invest	tigation, in my opinion	, death occurred at	the time, date and	place, and due t	to the caus	se(s) and manner stat	ted.
	To the within 2 To the comple	Σ	only one) 3 L Certifying Nurse 29b. Signature and title of certifier	Practitioner: To the best of	my knowledge,	death occurred at the 29c. License r			d. Date signed (_
	VAAN		Vall	Sm	100	015	870	2 1	prila	2,	2012	
	2 2/10		30. Name and address of person who co	ompleted cause of death (Ite	m 23a) (Type, F	phint)	Blod .	Hen B	upnie	2/	061	
	Stat Registra		31. Date filed (<i>Month, Day, Year</i>) APR 0 3 2012	32. Registrar's Sign	ature few	W						

Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1858 Lloyd Bergbower 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death BALTIMORE HOSPITAL OF BALTIMORE N/A MARYLAND Social Security Number If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Min. 12/2/1951 Virginia 218-60-3762 **Director** 1 🗶 M 2 🗆 F 60 BERG BOWER, 10c. City, Town or Location 10d. Inside City Limits Director "natural", or items 23a or 28a-f s edical Examiner must be notified N/A Baltimore Maryland 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5710 Kenmore Road 21210 J.S.A 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, by 1 Never Married 2 X Married 2 X No 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Law Enforcement Corporate Security Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 James Bergbower Mercy Gomez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5710 Kenmore Road Baltimore, Maryland 21210 Patricia Anne Smith / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Important: If it any injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem. 4/5/2012 Timonium, Maryland 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Secuentially list of neith on Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that the death certificate be executed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): ding physician Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Dav Year RAFFUSA tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the under CERTIFICATION APPROVED ò 1 Tyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 No 25. Was case referred to medical examiner?
1 √ Yes 2 ☐ No funeral director, To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Accident 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fi -2012 1210 2 🗹 No Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Addical Examiner on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination allows investigation, in my opinion, occarring to the best of my knowledge, death occurred at the time, date and place, and due to 29d. Date signed (Month, Day, Year) 1) 0066073 2012 tolle 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 2401 W. Belvedere Ave. Baltimore, MD 21215 stephen 31. Date filed (Month, Day, Year State Registrar

10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 158 AM Physician/ Year Month 3 Rebecca Jane Bryden Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Square HOSPITal Baltimore FRANKLIN Rosedale 5. Social Security Number 6. Sex If Under If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 Year 8. Date of Birth **Funeral** Min Hours Director 521-06-5927 1 □ M 2 🕱 F May 16, 1957 54 Wyoming Usual Residence of Decede 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f 1 Tes 2 X No Maryland Baltimore Nottingham 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral 23 Burnsway Court 21236 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify. Completed 3 Widowed 4 Divorced White injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Commercial and Elementary/Secondary (0-12) College (1-4 or 5+) 12 Residential Properties Property Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Department of Health and Menta Important: If firm 27 is marked any injury or other traumonce. and Mental မ McCain Hitt Robert Charles Rahlys Jane 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Thomas Bryden/Husband 23 Burnsway Court, Nottingham, MD 21236 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔲 Burial 2 💢 Cremation 3 🗌 Removal from State 4 Donaron 5 Other (Specify) 3/31/2012 Atlantic Crematory Glen Burnie, Maryland 22. Name and Address of Facility Home of Dulaney Valley Inc. 10 W. Padonia Road, Timonium, MD 21093 Clary Bryan W. 23a. Part 1. Enter the disease, or complications that caushock, or heart failure. List only one cause on each ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Pinal Physician/ In Farction myocardial disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Hubertension

Due to ras a consequence of: Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underl, in Cause (Disease or injury that initiated events abuse TODOCCO Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Day Year Pregnant at time of death Unknown q 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Disorder Seizure 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No Yes 2 N 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: ည 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28c. Injury at work? 28a. Date of injury 28b. Time of 28d. Describe how injury occurred (Month, Day, Year) 1 Natural injury 5 Pending 2 Accident 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State

ebecca

Baltimore, Division of Vital Records, P.O. Box 68760 Hospital or Attending Physician; 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of pertil 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Brendan Melvin 9000 FRANKLIN SQUARE DR Balto md APR 0 3 2012 32. Registrar's State Registrar DHMH 17 Rev 06-2011 ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 10c Per FH G926 4/13/2012 III and Mental Hygiene Copies Are Legible. State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April Susan Nabbe Beeler 2012 3 12:02p M Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Center Columbia Howard 264 246-78-6264 If Under 1 Year I If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months 67 **Director** 1 □ M 2 🛛 F Oct.18,1944 NJ items 23a or 28a-f show her must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director TN Noxville Knoxville 1 🗌 Yes 2 🕅 No Knox 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 37934 532 Farragut Commons Drive USA death v 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Armed Forces?

1 Yes 2 X No Black, White, etc. ō þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", Specify: White Completed 3 Widowed 4X Divorced Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) event, the Accountant Lockheed Martin Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be 1 Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ew once. ပ Robert William Nabbe Marjorie Tobin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jennifer Schantz/daughter 9206 Mellonbrook Rd. Columbia, Maryland 21045 20a. Method of Disposition
1 □ Burial 2 X Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Metro Crematory, Inc. 4/4/2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fureral Service License Stephanie, Custer 22. Name and Address of Facility Cremation Society of MD. Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ STAGE END LIVER disease or condition resulting in death) Medical Due to (or as a conse unce of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Litter Underlying Cause (Disease or injury Due to (or as a consequence of): requires that the death certificate be executed and trar that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death 2 X No 1 L Yes 2 D 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🗽 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s has death? certificate l 2 X No 1 Yes 2 No Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be Hospital: Other: 2 No ဂ္ 1
Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred iniury 1 X Natural 5 Pending 1 Yes 2 No eral Director; A filled in by the f Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location /Street and Number or Rural Route Number. 4 Homicide determined Hospital within 24 hours a To the Funeral C Medica 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D64395 APRIL 3, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 336 commbia. Ms 21044 DANIEUE DOBERMAN, MS 6 CEDAR LANE

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ thorin IDS 7AM March Medical 4a. Facility Name (if not institution, give street and n **Examiner** wn, or Location of Death 4c. County of Death N/A throve Security Numbe If Under If Under 24 Hrs. 8. Date of Birth Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Min 218-26-7200 Director 1 □ M 2 🔀 F X Usual Residence of Decede show 10a. State other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f XX Yes 2 No MD N/A Baltimore ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 23a 3805 Beech Avenue 21211 U.S.A. items Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? or Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. White If Yes, Give "natural", 3 XXWidowed 4 □ Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) of Health and Mental Hygiene, item 27 is marked other than College (1-4 or 5+) Secretary Printing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Patrick Lyons Elizabeth O'Keefe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Latkowsky (Daughter) 4231 Newport Avenue Baltimore, MD 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of Important: If it any injury or o Druid Ridge Cemetery 3/31/2012 4 Donation 5 Other (Specify) Pikesville, MD 22. Name and Address of Facility Purgee-Henss-Seitz Funeral Home, Inc. Signature of Funeral Service L 3631 Falls Road Balto, MD 21211 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exam burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy for in the past 12 months? Month Year Pregnant at time of death Other (specify) Day the a Unknown 9 Unknown Division of Vital Records, P.O. by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas page 2 autopsy performed Yes 2 No After this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: Yes 2 No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes Certificate: ¥28b. Time of 28d. Describe how injury occurred injury 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the f 2 | No ccident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License numbe 30. Name and address of person who completed cause of death (Item 23a) fType, Print)

State Registrar

31. Date filed (Month, Day, Year) 32. Registrar's Signature

10221

				State Registrar		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	C	ertifica	te of E	Death			Reg. No	0.		
				1. Decedent's Name (First, Middle, La	st)						2	Date of De	eath			3. Time of Death
		Physicia Medi		Clarence Cromw	vell Boy	le Sr.					1	Month	27,	^{ay} 2012	Year 2	6:45 A M
4	· Say	Examir		4a. Facility Name (if not institution, give	street and numb	per)		4b. City	, Town, or	Location	of Death			c. County		
	1	·		Upper Chesapea	ake Medi	cal Cer	nter	Be	l Ai	r]	Harfo	ord	
		Funeral		Social Security Number 6. S	Sex	7. Age (In yrs. I	as <i>t birthd</i> ay	/) If Und	er 1 Year Days	If Under Hours	24 Hrs. 8 Min.	. Date of Bir (Month, Da	th v Year		g. Birthp	place (State or Foreign
		Director			X M 2 □ F	85	Yrs.		50,0	710010		ar. 1		927		vland
		and show	_	Usual Residence of Decedent 10a. State 10b. County			y, Town or	Location		1	F. W	<u> </u>	-, т	721		0d. Inside City Limits
io		rylan -f sh	[왕		_										- [1 ☐ Yes 2 🕅 No
1		e Ma 7 28a notif	jë.	Maryland Harford	1	E	Bel A									
7		th the	je je	10e. Street and Number				1	p Code				-	itizen of V	√hat Cour	ntry?
7790		th wi	lae!	4 Forest Drive	T				.014					SA		
		r itel	H	11. Marital Status	12. Was Deced	ces?	S. 13	3. Was Dece If Yes, spe	dent of Hi cify Cuba	spanic Ori n, Mexicar	gin? (Specif n, Puerto Ric	y Yes or No- an, etc.)	.		e - Americ k, White,	an Indian, etc.
\bigcirc	36	after	d b	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes If Yes, Give			1 🗌 Yes	2X No	Specify:				Specify:	T.78a	
Q_i	ŏ	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If frem 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at	Completed by Funeral Director	15. Decedent's 8	Year or Dat	es.	16a Dec	cedent's Usi	ial Occup	ation			165.4	Kind of Bu		nite
	75	. 72 h an "n Medi	립	(Specify only highest gr	rade completed)	1 5 - \	(Giv	e kind of wo	ork done a		t of working		100. 1	XIII OI BU	15111655/111	dustry
8	212	vithir giene sr th		Elementary/Secondary (0-12)	College (1-	1 or 5+)		er/Ope	,	r			A11	to De	aler	ship
~	D	lled v I Hyg othe	Be	17. Father's Name (First, Middle, Last)			, 0,,,,,	JE / OF	Laco		er's Name (F	irst, Middle,				<u> </u>
5	<u>a</u>	be f lenta rked ic ev	은	Howard Benjamin	Boyle					Ethe	1 (nm	n) Boy	vman			
0	Maryland	Should be filed within 72 h and Mental Hygiene. T is marked other than "graumatic event, the Mec		19a. Informant's Name/Relationship (1			19b. Ma	ailing Addres	s (Street a						tate. Zio (Code)
3/27/		and 2 st Health a tem 27 is		Irene K. Boyle /	Wife		111	rest								,
	ē,	1 and of Hei item othe	1 3	20a. Method of Disposition			lace of Dis	position (Na	me of		Dat					wn, State
Õ	9	age ent o		1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		J.a.c	-	rematory or	,	· .	4.2	2012			**** 7 7	No
aca	3altimore,	nit. Partmartmortai		21. Signature of Funeral Service Licen		JSC.	Lgna	22. Name a	nd Addres	Se of Facilit	1. 4-2	-2012	FO	rest	HITI	, Maryland
	B	permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other ones.		Ateple 11.	Murl	4	- 1									nd 21009
)				23a. Part 1. Enter the disease, or com	plications that ca	used the deat	h. Do not e							II PIC	TLYIC	Approximate
V				shock, or heart failure. List only of Immediate Cause (Final	ne cause on eac	h line.	10	0	0	. 11	5					Interval Between Onset and Death
:01		Physician Medical		disease or condition resulting in death)	aX\(me	<u> </u>	Nax	fei	wal	16				_	
4 / 8	7	Examiner				rasaconsequ stroint		al Bl	eediı	ne						
wei			ē	Sequentially list conditions, if any, leading to immediate	b. —	r as a consequ				0						
3		ed	Examiner	cause. Enter Underlying Cause (Disease or injury		,	,-									
5		executed an and irial-transi	Exa	that initiated events resulting in death) Last	C. Due to (c	r as a consequ	uence of):									
Sm	0	cate be executed physician and the burial-transit	cal													
0	8760	ificate being physicias the bu	Medical		u											
\mathcal{L}	9			IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outc			_						23d Dat	e of delive	erv
)	Box	ath cert attendin I for use	Physician/	in the past 12 months?		irth 2 🗌 Feta ant at time of d		B		У				Mor		Day Year
3		requires that the de been signed by the should be detached	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 🗌 Unkno	own										
Š	P.0	res that t signed b d be deta	by P	Part II. Other significant conditions of	ontributing to de	ath but not res	ulting in the	e underlying	cause giv	en in Part	l.	23e. Did t	obacco	use contr	bute to th	e cause of death?
3	Ś	ires i sign	g p									1 🗀	Yes 2	□ No	3 🗆 Prot	pably 4 Unknown
JClanen	ord	requi	Completed									24a. Was	an	24b. V	Vere autor	osy findings available
J	ec	e law e has	mg									auto		p	rior to cor eath?	mpletion of cause of
7	of Vital Records, P.O.	ysician: The la s certificate ha director, page	ပ္	25. Was case referred to medical					06 DI	D	+ (Ohi	1 🗌 Yes	2 X N	lo 1	Yes	2 No
9	/ita	sicial certi irecto	9 Be	examiner? 1 \(\sum \) Yes 2 \(\sum \) No	Hospital:				Othe	er.	th (Check or					
70	Ž	Phys r this eral di	2	27. Manner of Death	28a, Date o	npatient 2 finjury	ER/Outpat 28b. Time	· ·	OA 28c. Injury		ursing Home	5 L Resi)
1609	n	ding th. After	cate	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigatio	(Month	, Day, Year)	injury		work			i. Describe	now injui	ry occurre	u	
	Sio	Attending Physician: The law requires that the death cert ar death. ector: Afer this certificate has been signed by the attendir by the funeral director, page 2 should be detached for use	Certificate:	3 Suicide 6 Could not b	e 280 Bloom	of Injury - At ho	me, farm, s			700 2		Location (Street an	nd Numbe	r or Rural	Route Number,
Ü	Division	Dire dir b		4 ☐ Homicide determined	buildin	g, etc. (Specify)	,	,,			City or To			, 0, 7,0,0	, rectorium son,
318		To the Hospital or Attendir within 24 hours af er death. To the Funeral Director: Af completely filled in by the fu	Medical	29a. Certifier Certifying Phy	sician: To the be	st of my know	edge, deat	h occurred a	at the time	a. date and	place, and	due to the c	ause(s) a	and mann	er as state	
8		e Ho n 24 h e Fur	Med	29a. Certifier (Check only one) 3 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 4 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 4 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 4 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 4 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 4 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 4 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and due to the cause(s) and due to the cause(use(s) and manner stated.				
2		To the within 2 To the comple	2	29b. Signature and title of certifier	0 (1			20	r License	number			204 Da	to cianed	(Month I	Day Vearl
-		, \		· Co	Lelle	m 1	10	1	000	63:	220		3/	27/	20	1.20
Q		May 13.		30. Name and address of person who	completed cause	of death (Item	23a) (Type	, Print)		^				2/1	<u>au 1</u>	
8		13 %		GeorgeIsckano	5 500	of death (Item	cha	Saip	eake	2 Dri	ve, B	el Air	- m	D S	2101	4
7		Sta	te∗	31. Date filed (Month Ray (Year) 20	2. Re	gistrar's Signa	ure	241								<u> </u>
7	3/5	Registra	ar	APR U 3 20	1 Klings	a p	19									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 Month Physician/ March 30, 7:24 P M Dee Barker Elaine Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Montgomery Bethesda Suburban Hospital 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 213-48-1429 **Director** 1 □ M 2 🗓 F Yrs February 28, 1948 Washington, D.C. 64 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location notified at 10a State Director 1 Tes 2 X No Potomac Maryland Montgomery 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Medical Examiner must be Funeral items 23a 20854 United States 9201 Pegasus Court Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces Black, White, etc ō þ 1 Never Married 2 Married Yes 2 X No Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify If Yes, Give Year or Dates. "natural", 3 Widowed 4 X Divorced Completed White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker n and Mental Hygier 12 Elaine, Barker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Frances Elaine Hodge Richard Dee Barker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 2 Bentbrook Lane, Sandy, Utah 84092 Michael E. Dismuke / Son 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a Method of Disposition 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) ${\tt ApriĬ}^{\^{}}$ Parklawn Memorial Park 2012 4 Donation 5 Other (Specify) Rockville, Maryland 21. Signature of Funeral Service Licenses Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 M01360 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Phy i ian/ Bowel Perforation disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner 2009 Metastatic Ovarian Cancer Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Exami and the burial-tran Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ signed by the atter in the past 12 months?
1 Yes 2 X No Month Day Pregnant at time of death g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has 1 ☐ Yes 2 🛣 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 1 within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, 1 25. Was case referred to medica 26. Place of Death (Check only one) Be 1 ☐ Yes 2 🗓 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 🔀 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 XNatural 5 Pending work?
1 Yes 2 No Accident
Suicid M Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide determined Medical X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 29b. Signature and title 29d, Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar Shannon O'Connor, M.D.

Registrar's Signaty

9707 Medical Center Drive, Ste 300, Rockville, Maryland 20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For	State of Ma	aryland	l / Departmer			ental Hyg	giene		
		State Registrar			Certificat	e of Death	1	F	Reg. No. 2	112	10223
Physic	ian/	Decedent's Name (First, Middle	_					2. Date of Dea	th Day	Year	3. Time of Death
Med	lical	Thomas	Lee		Brasur			Monch	2/5 0	012	00:19 M
Exam	iner	4a. Facility Name (if not institution	i, give street and number)	1.	11 4b. City,	Town, or Location	n of Death	1	4c. County	of Death	100
Funera	1	5. Social Security Number	6. Sex 7. Age	(In yrs. las	t birthday) If Unde Months	1 Year If Undo		8. Date of Birth (Month, Day	1		ace (State or Foreign
Directo	r	214-78-6995 Usual Residence of Decedent	1 🗶 M 2 🗆 F	49	Yrs.	Bays Hours		Sept.2			y 1and
and show	٦			10c. City,	Town or Location					10	Od. Inside City Limits
Maryli 28a-f otifiec	Director	MD Wo:	rcester			Ocean Ci	ty				1XXYes 2 □ No
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at			dge Rd. #6		10f. Zip	Code 21842			10g. Citizen of V Uni		ry? tates
death v items ner mu	Funeral		12. Was Decedent Ev Armed Forces?		13. Was Deced	lent of Hispanic C ify Cuban, Mexic	Origin? (Spec can, Puerto R	ify Yes or No- ican, etc.)		e - America k, White, e	
036 rs after raf", or	ed by	1 ☐ Never Married 2 🛣 Mar 3 ☐ Widowed 4 ☐ Divorced	If Van Civo	^{No}	1 🗆 Yes	2 X ÌNo Speci	fy:		Specify:	Wh	ite
15-0 2 hour "natu	plet	15. Decede (Specify only high	nt's Education est grade completed)			k done during me	ost of working	g	16b. Kind of Bu	usiness/Ind	ustry
2121 vithin 7 iene. ir than the Me	Completed	Elementary/Secondary (0-12)	College (1-4 or 5-	+)	life. DO NOT use	retired) ook			Rest	auran	t
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", o any injury or other traumatic event, the Medical Exam	To Be	17. Father's Name (First, Middle,					_	(First, Middle,	Maiden Surname	_	ee
re, Marylanc and 2 should be file Health and Mental I tem 27 is marked o	-	Lee 19a. Informant's Name/Relations		Brasu			Joyce	D. A. Museka	. O't T		
Ma 12 shc lith an 27 is 1		Patricia J. Br		- 1	19b. Mailing Address 12704 01						21842
or Head of Head of Head of Head of Item		20a. Method of Disposition		20b. Pla	ace of Disposition (Nametery, crematory or o	ne of		ate	20c. Location -		wn, State
imo Page ment o		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (formed Ser		03/29	9/2012	Beth	esda,	MD
Balti permit. I Departr Importa any inju	9	21. Signature of Funeral Service	Licensee M	10038	Rapp P33 G	Funeral ist Ave.	and Ci	rematio ver Spr	n Servi ing,MD	ces 20	910
		23a. Part 1. Enter the disease, o shock, or heart failure. List	r complications that caused only one cause on each line.	the death.	Do not enter the mod	e of dying, such a	as cardiac or	respiratory arr	est,		Approximate Interval Between
Physician	-	Immediate Cause (Final disease or condition resulting in death)	_a Seps								Onset and Death
Medica Examine	_	resulting in death)	Due to (of as a	conseque	ence of):						
	ner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	conseque	ence of):						
cuted nid	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c			_					
60 control of the period of the purial-transit	dical E	resulting in death) Last	Due to (or as a	conseque	ence ot):						
760 cate be physic	edic		d								
certification	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of			pregnancy			23d. Da	te of delive	ery
ords, P.O. Box 6876 requires that the death certificat been signed by the attending ph should be detached for use as it	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at						Mo	nth	Day Year
P.O.	by Ph	Part II. Other significant conditi	ons contributing to death bu	ut not resu	Iting in the underlying	cause given in Pa	art I.	23e. Did to	bacco use cont	ribute to th	e cause of death?
dS, quires en sign	led t							1 🗆 '	Yes 2 No	3 Prob	ably 4 Inknown
COr law rec nas bee	Completed		·					24a. Was autop	sy		sy findings available npletion of cause of
Re T: The Ticate P		25. Was case referred to medical	10			00 81 / 0		1 Tes		1 Yes	2 🗆 No
/ita	To Be	examiner?	Hospital:	ent 2 \square E	R/Outpatient 3 🗆 D	26. Place of D			lence 6 🗆 Oth	er (Snecify)	
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the rs after death. In Director: After this certificate has been signed by the funeral director, page 2 should be detached in by the funeral director, page 2 should be detached.		27. Manner of Death 1 Natural 5 Pendi	28a. Date of injur	у 2		8c, Injury at work?	2		ow injury occurr		
sion attendii death. stor: At	Certificate:		igation not be	n. At box	M M	1 \(\text{Yes} \) 2	_	Of Leasting /S	Street and Alumb	or or Puml	Pouto Number
Jivision I or Attended after death Director:		4 Homicide determ	nined 28e. Place of Inju building, etc		ne, farm, street, factor	y, office		City or Tow	Street and Numb n, State)	er or murai	noute Number,
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Medical	(Check 2 Medical	g Physician: To the best of i Examiner: On the basis of ex g Nurse Practitioner: To the	kamination	and/or investigation, in	my opinion, death	occurred at t	the time, date a	nd place, and du	e to the cau	ise(s) and manner stated.
To the vithin To the comp	2	29b. Signature and title of certific			20	License numbe	r		20d Date signer	d (Month I	Day Yearl
\		adenby				Y1335	3		march	27,	2012
Ja		30. Name and address of person Dr Sravanth	y Pataparl	a 11	23a) (Type, Print) 50. E. Car	71335	Sal	isbur	y mp	218	761
S Regis	tate trar	31. Date filed (<i>Month, Day, Year</i>) APR 0 3 2012	32. Registra	r's Signatu	ire						
ricgis	41-611	AFILO O LOIL	person p.	EF G	Note:						

29a. Certifier (Check only one)

29b. Signature and title of certifier

DR Noshin

31. Date filed (Month, Day, Year)

N. Qaisrani

9000

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Quistani

Director

Completed by Funeral

To Be

Physician/

Medical

Examiner

Funeral Director

28a-f show

Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland

Medical Certificate: To Be Completed by Physician/Medical Examiner

For State Registrar		or ivial ylar		Sertifica:			and N	/lental Hy	Reg. N	00	112	1 2	022
. Decedent's Name (First, Midd	· · · · · · · · · · · · · · · · · · ·							2. Date of D	eath	Day	Year		ne of Death
Joseph R. Boze				- 				3	3	0 2	012		15 A M
a. Facility Name (if not institution FRANKLI'N Sa	-		1	4b. City		Location of			4	County (Sc.)	of Death		
. Social Security Number		7. Age (In yrs.			er 1 Year	If Under	24 Hrs.	8. Date of B			9. Birth	place (Sta	ite or Foreign
214-56-7474	1 🛛 M 2 🗆 F		62 yr	Months s.	Days	Hours	Min.	Dec 25			Mar	ylan	d
Usual Residence of Decedent 0a. State 10b. Count	у	10c. Cit	ty, Town o	r Location							Т	10d. Insid	e City Limits
aryland E	Baltimore				Es	sex						1 🗆	Yes 2 XNo
De. Street and Number				10f. Zi	p Code	01.001			10g. (Citizen of \			
506 North Marl		edent Ever in U.	e I	13 Was Dace		21221		ecify Yes or No	_	_	ed S		
I. Marital Status 1 ☐ Never Married 2 🙀 Ma	Armed Fo	rces? 2 X No	·	If Yes, spe	cify Cuba	n, Mexicar	n, Puerto	Rican, etc.)			ce - Ameri ck, White,	etc.	
3 Widowed 4 Divorce	ed If Yes, Giv Year or Da	e		1 Tes	2 [X] No	Specify:				Specify.	:	Whit	e
(Specify only high	ent's Education hest grade completed)		(G	ecedent's Usu live kind of wo e. DO NOT us	ork done a		t of work	ing	16b.	Kind of B	usiness/Ir	ndustry	
Elementary/Secondary (0-12)	College (1	-4 or 5+)		k Lift	,	rator	2		Wa	areho	ouse		
7. Father's Name (First, Middle,	Last)		-			18. Moth	er's Nam	e (First, Middle	, Maide	n Surname	e)		
1	zeman		177			Minr		0gle					
9a. Informant's Name/Relation ${\sf Gail}\; {\sf Bozeman} \; /$			1	_				Essex,					
Da. Method of Disposition 1 ☐ Burial 2 🂢 Cremation	n 3 🗆 Removal from		Place of D	isposition (Na	me of			Date	200	Location -	- City or T	own, Stat	е
		State I '	cemetery,	crematory or	other plac	e)		Date	200.				
4 Donation 5 Other	(Specify)	Me	tro (Cremato	other plac ory I	ne (03/31	1/2012	Ва	ltimo	ore,	Mary	
4 Donation 5 Other	(Specify)	Me	tro (22. Name a	other place $ ext{pry} \; \; ext{I}$ nd Addres	nc (03/31 vCren	1/2012 mation	Ba.	ltimo iety	ore,	Mary aryl	and In
1. Signature of pneral Service	(Specify) Licensee ALVSOI or complications that of	Me n K Tay	tro (22. Name a 299 Fi	other place ory I nd Addres ceder	nc (ss of Facilit ick I	03/31 Cren Road	l/2012 mation , Balti	Ba: Soc	ltimo iety	ore,	Mary larylarylaryl nd 2	and Inc 1228 _{Imate}
4 Donation 5 Other 1. Signature of Ineral Service 1. Sa. Part 1. Enter the disease, shock, or heart failure. List mmediate Cause (Final	(Specify) Licensee A VSOI or complications that confly one cause on ea	Me n K Tay	tro (lor th. Do not	22. Name a 299 Fi	other place Ory I nd Addres ceder de of dying	ne (ss of Facilit ick E g, such as	03/31 tyCren Road	1/2012 mation , Balti	Ba: Soc	ltimo iety	ore,	Mary lary1 nd 2 Approx Interval Onset a	and Inc 1228 imate Between and Death
1. Signature of Funeral Service 23a. Part 1. Enter the disease, coshock, or heart failure. List mmediate Cause (Final lisease or condition	(Specify) Licensee A VSOI or complications that confly one cause on ea	Me n K Tay	tro (lor th. Do not	22. Name a 299 Fi	other place Ory I nd Addres ceder de of dying	ne (ss of Facilit ick E g, such as	03/31 tyCren Road	1/2012 mation , Balti	Ba: Soc	ltimo iety	ore,	Mary lary1 nd 2 Approx Interval Onset a	and Inc 1228 imate Between
1. Signature of pneral Service 23a. Part 1. Enter the disease, c shock, or heart failure. List mmediate Cause (Final disease or condition esulting in death) Sequentially list conditions,	Control on the control of the contro	Men K Tay caused the deat ach line. Moderated the deat ach line.	th. Do not	22. Name a 299 Fi enter the model along	other place Ory I nd Addres ceder de of dying	ne (ss of Facilit ick E g, such as	03/31 tyCren Road	1/2012 mation , Balti	Ba: Soc	ltimo iety	ore,	Mary lary1 nd 2 Approx Interval Onset a	and Inc 1228 imate Between and Death
4 Donation 5 Other 1. Signature of prieral Service 23a. Part 1. Enter the disease, condition, or heart failure. List mediate Cause (Final disease or condition esulting in death) Sequentially list conditions, fany, leading to immediate bauce. Enter the certifying	Control on the control of the contro	Me n K Tay	th. Do not	22. Name a 299 Fi enter the model along	other place Ory I nd Addres ceder de of dying	ne (ss of Facilit ick E g, such as	03/31 tyCren Road	1/2012 mation , Balti	Ba: Soc	ltimo iety	ore,	Mary lary1 nd 2 Approx Interval Onset a	and Inc 1228 imate Between and Death
4 Donation 5 Other 1. Signature of Fineral Service 3a. Part 1. Enter the disease, chock, or heart failure. List mediate Cause (Final lisease or condition esulting in death) Sequentially list conditions, any, leading to immediate cause. Enter the death, is any, leading to immediate cause. Enter the death, is any, leading to immediate cause. Enter the death, is any leading to injury hast initiated events	(Specify) Licensee AL VSOI or complications that or only one cause on ea a. Due to (Men K Tay caused the deat ach line. Moderated the deat ach line.	tro (lor lor lor lor lor lor lor lor lor lor	22. Name a 299 Fi enter the mod	other place Ory I nd Addres ceder de of dying	ne (ss of Facilit ick E g, such as	03/31 tyCren Road	1/2012 mation , Balti	Ba: Soc	ltimo iety	ore,	Mary lary1 nd 2 Approx Interval Onset a	and Inc 1228 imate Between and Death
4 Donation 5 Other 1. Signature of Pyneral Service 23a. Part 1. Enter the disease, on shock, or heart failure. List immediate Cause (Final disease or condition esulting in death) Sequentially list conditions, frany, leading to immediate bause. Enter or derlying Cause (Disease or injury that initiated events	(Specify) Licensee AL VSOI or complications that or only one cause on ea a. Due to (caused the deat ach line. Moderate and the deat ach line. Moderate and the deat ach line.	tro (lor lor lor lor lor lor lor lor lor lor	22. Name a 299 Fi enter the mod	other place Ory I nd Addres ceder de of dying	ne (ss of Facilit ick E g, such as	03/31 tyCren Road	1/2012 mation , Balti	Ba: Soc	ltimo iety	ore,	Mary lary1 nd 2 Approx Interval Onset a	and Inc 1228 imate Between and Death
4 Donation 5 Other 1. Signature of Fyneral Service 23a. Part 1. Enter the disease, on shock, or heart failure. List mediate Cause (Final disease or condition resulting in death) Sequentially list conditions, fany, leading to immediate Dause (Disease or injury that initiated events resulting in death) Last	(Specify) Licensee Al VSOI or complications that conly one cause on each of the conly one cause of the	caused the deat tach line. (or as a consequence of the consequence of	th. Do not th. Do not uence of):	22. Name a 299 Fi enter the mod	other place Ory I nd Addres ceder de of dying	ne (ss of Facilit ick F g, such as	03/31 tyCren Road	1/2012 mation , Balti	Ba: Soc	ltimo iety	ore,	Mary lary1 nd 2 Approx Interval Onset a	and Inc 1228 imate Between and Death
4 Donation 5 Other 1. Signature of Tyneral Service 23a. Part 1. Enter the disease, c	complications that control on the control of the co	caused the deat ich line. Magnetic for as a consequence of pregnation and the consequence of the consequence	tro (Ior th. Do not uence of): uence of): uence of): ancy al death	22. Name a 299 F1 enter the model al	other place ory I nd Address ceder de of dying I n F	ne ((se of Facilities of Facil	03/31 tyCren Road	1/2012 mation , Balti	Ba: Soc	ltimo iety e, Ma	ore,	Mary lary1 nd 2 Approx Interval Onset	and Inc 1228 imate Between and Death
4 Donation 5 Other 1. Signature of pineral Service shock, or heart failure. List mmediate Cause (Final lisease or condition esulting in death) Sequentially list conditions, fany, leading to immediate value. Enter the driphy facuse (Disease or injury hat initiated events esulting in death) Last FEMALE: Bb. Was decedent pregnant in the past 12 months? 1	complications that converges on each of the converges of the converges on each of the converges on the converg	m K Tay caused the deat ach line. M	tro (lor lor lor lor lor lor lor lor lor lor	22. Name a 299 F1 enter the model at a 1	pregnance	ick I	03/31 Cren Road cardiac	1/2012 nation , Balti or respiratory a	Ba: Soc: more	ltimo iety e, Ma	ore, of Maryla	Marylaryl aryl aryl aryl aryl aryl aryl a	and Inc 1228 imate Between and Death
4 Donation 5 Other 1. Signature of Fyneral Service 23a. Part 1. Enter the disease, cance, or heart failure. List mmediate Cause (Final disease or condition resulting in death) Sequentially list conditions, fany, leading to immediate pauce. Enter the duriph, a Cause (Disease or injury hat initiated events resulting in death) Last FEMALE: 3b. Was decedent pregnant in the past 12 months? 1	complications that converges on each of the converges of the converges on each of the converges on the converg	m K Tay caused the deat ach line. M	tro (lor lor lor lor lor lor lor lor lor lor	22. Name a 299 F1 enter the model at a 1	pregnance	ick I	03/31 Cren Road cardiac	nation, Balti or respiratory a	Ba. Soc. more wrest,	ltimo iety e, Ma	ore, of Maryla are of deliventh	Mary lary1 nd 2 Approx Interval Onset a	and Inc 1228 imate Between and Death
4 Donation 5 Other 1. Signature of Ineral Service shock, or heart failure. List mediate Cause (Final lisease or condition esulting in death) Sequentially list conditions, any, leading to immediate cause. (Disease or injury hat initiated events esulting in death) Last FEMALE: B. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	complications that converges on each of the converges of the converges on each of the converges on the converg	m K Tay caused the deat ach line. M	tro (lor lor lor lor lor lor lor lor lor lor	22. Name a 299 F1 enter the model at a 1	pregnance	ick I	03/31 Cren Road cardiac	1/2012 nation Balti or respiratory a	Ba. Soc. more wrest,	ltimo iety e, Ma 23d. Da Mo use contr	ore, of Maryla aryla attended to the contribute	Mary lary1 nd 2 Approx Interval Onset a	Year Unknown
4 Donation 5 Other 1. Signature of pineral Service shock, or heart failure. List mmediate Cause (Final lisease or condition esulting in death) Sequentially list conditions, fany, leading to immediate value. Enter the driphy facuse (Disease or injury hat initiated events esulting in death) Last FEMALE: Bb. Was decedent pregnant in the past 12 months? 1	complications that converges on each of the converges of the converges on each of the converges on the converg	m K Tay caused the deat ach line. M	tro (lor lor lor lor lor lor lor lor lor lor	22. Name a 299 F1 enter the model at a 1	pregnance	ick I	03/31 Cren Road cardiac	23e. Did	Ba. Soc. more	ltimo iety e, Ma 23d. Da Mo use contr 2 \(\text{No} \)	ore, of Maryla aryla attended to the contribute	Mary lary ary nd 2 Approx Interval Onset a On	Year Unknown
23a. Part 1. Enter the disease, chock, or heart failure. List mmediate Cause (Final disease or condition resulting in death) Sequentially list conditions, fany, leading to immediate Dause (Disease or injury hat initiated events resulting in death) Last FEMALE: 3b. Was decedent pregnant in the past 12 months? 1	(Specify) Licensee Al VSOI The complications that confly one cause on each of the confly one cause on each of the confly one cause of	m K Tay caused the deat ach line. M	tro (lor lor lor lor lor lor lor lor lor lor	22. Name a 299 F1 enter the model at a 1	pregnanc pecify) cause giv	y y ace of Dea	03/31 Cren Road, cardiac	23e. Did	Ba. Soc. more tobacco	ltimo iety e, Ma 23d. Da Mo use contr 2 \(\text{No} \)	ore, of Maryla aryla ate of deliverable on the stribute to to the stribute of the stribute o	Mary lary ary nd 2 Approx Interval Onset a On	Year Unknown
23a. Part 1. Enter the disease, c shock, or heart failure. List mmediate Cause (Final lisease or condition esulting in death) Sequentially list conditions, fany, leading to immediate ause (Disease or injury hat initiated events esulting in death) Last FEMALE: Bb. Was decedent pregnant in the past 12 months? 1	(Specify) Licensee Al ysor or complications that converge control on the converge cause on early one cause on early one cause on early one cause on early one to the converge cause of the converge cau	Me n K Tay caused the death and line. M	tro (Ior th. Do not uence of): uence of): uence of): ancy al death death death ER/Outp.	22. Name a 299 F1 enter the model of the line of the l	pregnance pecify)	ick I ick I g, such as	D3/3] Cren Road Cardiac Cardiac Circo	23e. Did 24a. War per 1 Yes k only one)	Ba. Soc. more trest, tobacco	23d. Da Mc	ore, of Maryla aryla ate of deliverable on the control of the co	Mary lary1 nd 2 Approx Interval Onset a Onset	Year Unknown
4 Donation 5 Other 1. Signature of pread Service 23a. Part 1. Enter the disease, on shock, or heart failure. List immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, fany, leading to immediate Dauble. Enter the original product of the formal	Complications that control on the control of the co	Me n K Tay caused the death and line. M	tro (lor	22. Name a 299 F1 enter the model in a 1	pregnance pecify) 26. Plactocal Other place of the pecify of the pecify of the pecific pecifi	y y ace of Dea ar 4 \(\) No we at	D3/3] Cren Road Cardiac Cardiac Circo	23e. Did 24a. War autu per 1 Yes	Ba. Soc. more trest, tobacco	23d. Da Mc	ore, of Maryla aryla ate of deliverable on the control of the co	Mary lary1 nd 2 Approx Interval Onset a Onset	Year Unknown

29d. Date signed (Month, Day, Year)

DR Baltomd

30-2012

21237

Registrar DHMH 17 Rev 06-2011

State

29c. License number

FRANKLIN SQUARE

064167

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Butler Physician/ W Year = Imer March 300 М Medical 2017 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Locust Wood Road Severn Anne Arundel Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Min Hours 214-38-6440 **Director** 1 ፟፟፟፝ M 2 □ F Yrs 06/05/1939 72 MD Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Tes 2 No Anne Arundel Severn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 7861 Locust Wood Road 21144 U.S.A. death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🗶 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Completed 3 Widowed 4 X Divorced Specify. Year or Dates White other traumatic event, the Medical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 11 Welder Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Elmer Walter Butler, Sr. Martha Corinne Steiner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Mrs. Sandra Harman / sister 672 221st Street, Pasadena, Maryland 21122 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Important: If it any injury or o 1X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) 4/4/2012 MD National Mem. Park Laurel, Maryland Signature of Funeral Service Licenses 22. Name and Address of Facility 1 2nd Ave, SW Glen Burnie, MD M01357 Singleton Funeral & Cremation Services, P.A. 23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final me tassatic Frophaneal Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to or as a conse uence of burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical death certificate be Box 68760 the attending IF FEMALE: asn 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Pregnant at time of death 5 Other (specify) Day Year Yes 2 No ed by the a 1 Yes 2 L 9 Unknown a Unknown Division of Vital Records, P.O. signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Jas After this certificate 1 Yes 2 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2. No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural injury 5 Pending death. 2 Accident
3 Suicide filled in by the Investigation within 24 hours after deat To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

J State

DHMH 17 Rev 06-201

31. Date filed (Month, Day, Year) Registrar

29b. Signature and title of certifier

NS RajapaKie ND

n S Rajapaliu Mo

7835

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Smith

29c. License number

00057465

29d. Date signed (Month, Day, Year)

Baltimore MD 21209

3/30/12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 2:33PM Physician/ March Clark 30,2012 David Nathaniel Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Bel Air Upper Chesapeake Medical Center If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth Social Security Number **Funeral** Days Hours 220-42-9286 Usual Residence of Dece **Director** 1 X M 2 □ F June 8, 1945 Maryland 66 or 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State **Funeral Director** 1 Yes 2 No Maryland | Harford Edgewood 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe pe 23a United States 21040 610 Sequoia Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2**X** No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. "natural", or 1 Never Married 2XXMarried þ Saltimore, Maryland 21215-0036 Specify: White 1 Yes 2XXNo Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) the Me Elementary/Secondary (0-12) College (1-4 or 5+) id Mental Hygiene. marked other tha Construction Brick Layer 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Health and Mental tem 27 is marked ည Thomas Leonard Clark Anna Marie Griffin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 610 Sequoia Drive Edgewood, Maryland 21040 Lesley Ann Clark / Wife permit. Page 1 and 2
Department of Healt
Important: If item 2
any injury or other: 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Aprilate1, Evanster funeral of Charlet 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2012 Forest Hill. Marvland Bel Air 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Service—BelAir Signature Funeral Service Licenses 3 Newport Drive Forest Hill, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on for use on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ·UNG INKROWN disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Due to (or as a consequence of): resulting in death) Last Physician/Medical Nathanie IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month 5 Other (specify) Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 XYes 2 No 3 Probably 4 Unknown 06esi+ 24b. Were autopsy findings available prior to completion of cause of death?
 1 □ Yes 2 □ No 24a. Was an autopsy perform 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 1 🗌 Yes 2 **2** No Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Clark, injury Natural 5 Pending Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined To the Hospital within 24 hours a To the Funeral C completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and titl 10 de resabeaka 30. Name and mpleted cause of death (Itam 23a) (Type, Print) ress of person who c (Month, Day, Year) 32. Registrar's Signature State 3 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

			For State	State of Maryland				Mental Hygi	ene	
			Registrar 1. Decedent's Name (First, Middle, Last)		Cer	tificate of D	eath		eg. No. 20 2	10227
	Physicia Medic	al	Anthony	ChRISTIA	ary!	JR		2. Date of Death	31,2012	3. Time of Death 431 PM
	Examin	er	4a. Facility Name (if not institution, give str 8668 Doves Fly Way	eet and number)		4b. City, Town, or Laurel	Location of Death		4c. County of Death	1
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. Ia	st birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	9. Birti	nplace (State or Foreign
	Director		578-50-0349 1 ☑ Usual Residence of Decedent	M 2 □ F 7	5 Yrs.	WORTHS Days	Tiours Iviiri.		,1936 Wash	ington DC
	and show	rol	10a. State 10b. County	10c. City	, Town or Loc	ation	<u></u>	1 0	, 2,500 ,,,,,,,	10d. Inside City Limits
	Maryl 28a-f otifie	Director	MD Howard	Lau	rel					1 🗌 Yes 2 🗶 No
	n with the is 23a or nust be n	Funeral D	10e. Street and Number 8668 Doves Fly Way			10f. Zip Code 20723			0g. Citizen of What Co USA	untry?
336	ge 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		11. Marital Status 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	2. Was Decedent Ever in U.S Armed Forces? 1 X Yes 2 No 195 If Yes, Give Year or Dates.	5-	Vas Decedent of His Yes, specify Cubar ☐ Yes 2 🏋 No	n, Mexican, Puerto		14. Race - Amer Black, White Specify: Whi	, etc.
2-0	hours natur dical I	olete	15. Decedent's Educ (Specify only highest grade	ation	16a. Deced	ent's Usual Occupa		[16b. Kind of Business/I	ndustry
2121	within 72 giene. er than ' , the Me	Completed by	Elementary/Secondary (0-12)	College (1.4 or F.)		ind of work done do NOT use retired) ighter	uring most of work		C Fire Dep	artment
Maryland 21215-0036	d be filed Mental Hy Irked oth	To Be	17. Father's Name (First, Middle, Last) Anthony A. Christia	ani			18. Mother's Nam	e (First, Middle, M enihan	aiden Surname)	
Man	d 2 should alth and Malth		19a. Informant's Name/Relationship (Type Carole A. Christian						City or Town, State, Zip	
altimore,	age 1 and ent of Hea nt: If item y or othe		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	emetery, crem	sition (Name of latery or other place		1	20c. Location - City or Saltimore, M	
Baltir	permit. Page 1 a Department of I Important: If ite any injury or ot		21. Signature of Funeral Service Licensee		ter 22	Name and Addres	s of Facility Cre	emation S	ociety of	MD.Inc.
ш	<u></u>	- 11	23a. Part 1. Enter the disease, or complic	uove					e,Maryland	
Ę	h, sician/		shock, or heart failure. List only one Immediate Cause (Final disease or condition	cause on each line.	471		CANC		,	Approximate Interval Between Onset and Death
	Medical Examiner	<u>.</u>	resulting in death) Sequentially list conditions, b.	Due to (or as a consequ	ence of):					
	cuted nd ransit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequ	епсе оі).					
09	ate be executed physician and the burial-transit	dical E	resulting in death) Last	Due to (or as a consequ	ence of):					
9289	tificate ng phy e as th	Med	IF FEMALE:						1000	
Box 6	ss that the death certificate be executed igned by the attending physician and be detached for use as the burial-transi	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c. If yes, outcome of pregnar 1 ☐ Live Birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	Ideath 3	Ectopic pregnanc Other (specify)	у		23d. Date of deli Month	very Day Year
s, P.O.	The law requires that the ate has been signed by the page 2 should be detach	þ	Part II. Other significant conditions cont	ributing to death but not resu	ulting in the u	nderlying cause giv	en in Part I.	23e. Did tob	acco use contribute to	the cause of death?
ords	require been si should I	lete						24a. Was an		opsy findings available
Rec	sician: The law r certificate has b lirector, page 2 s	Completed						autopsy perform 1 🗆 Yes 2	ied? death?	ompletion of cause of
ital	ysician: is certific director,	Be	25. Was case referred to medical examiner? 1 Yes No	spital:		Othe	nce of Death (Chec	•		
Division of Vital Records,	> 000	ate: To	27. Manner of Death 1 Natural 5 Pending	1 Inpatient 2 28a. Date of injury (Month, Day, Year)	ER/Outpatien 28b. Time of injury	28c. Injury	4 ☐ Nursing Heat	ome 5 Resider 28d. Describe hov	nce 6 Other (Speci v injury occurred	fy)
ivisio	l or Attending after death. Director: After I in by the fune	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hos building, etc. (Specify)			163 2 2 1140	28f. Location (Street) City or Town,	eet and Number or Rur State)	al Route Number,
	to the Hospital or Attending Physician: within 24 hours after death within 25 completely filled in by the funeral director, completely filled in by the funeral director,	Medical	(Check 2 \(\subseteq \text{Medical Examine} \)	i an: To the best of my knowler: On the basis of examination Practitioner: To the best of m	and/or invest	gation, in my opinio	n, death occurred a	t the time, date and	l place, and due to the c	ause(s) and manner stated.
	To the within 2 To the comple	~	29b. Signature and title of certifier	7 /h -	No	29c. License			od. Date signed (Month	
x \			30. Name and address of person who con	apleted cause of death (Item	23a) (Type, P	rint)	011	P.	nn/1 </th <th>21061</th>	21061
,	Stat		31. Date filed (Month, Day, Year)	32. Registrar's Signat	ure M	-15 kg	DIVI	yen!	MINIC	-6/
	Registra	ar	APR 0 3 2012	un d. de	ale					

DHMH 17 Rev 06-2011

				e or Print in				-	_	jible.
			1 _ State	ate of Marylan				nd Mental Hy	giene	"/
	H		Registrar 1. Decedent's Name (First, Middle, Last)		Cer	tificate of l	Death	2. Date of De	Reg. No.	3. Time of Death
	Physicia Medi		Joseph D. (Comotto				March		2012 9:SIPM
with the	Examir		4a. Facility Name (if not institution, give street	,		4b. City, Town, o			4c. County	
100	Funeral		1810 Weyburn Roa 5. Social Security Number 6. Sex	7. Age (In yrs. I	ast birthday)	If Under 1 Year		Hrs. 8. Date of Bir	th	g. Birthplace (State or Foreign
	Director		215-32-5838	2 🗆 F	76 Yrs.	Months Days	Hours f	Min. (Month, Da Feb. 2	y, Year) 27 , 1936	Country)
	and show	5	Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Loc	cation			•	10d. Inside City Limits
	Maryla 28a-f otified	Director	MD Baltimor	·e	Rosed	lale				1 ☐ Yes 2X No
	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	a D	10e. Street and Number 1810 Weyburn Roa	ıd		10f. Zip Code 2123	3.7		10g. Citizen of V	What Country?
	leath v items er mu	Funeral	11. Marital Status 12. W	as Decedent Ever in U.S	S. 13. V		lispanic Origin'	? (Specify Yes or No-		e - American Indian,
36	after o	þ	1 Never Married 2 LAMarried 1	Yes, Give Yes, Give		Yes 2 XIVo		uerto Rican, etc.)	Blac Specify	ck, White, etc. White
2-00	hours nature dical E	Completed	15. Decedent's Education		16a. Deced	lent's Usual Occup	pation			usiness/Industry
121	thin 72 ne. than "	dmo:		ollege (1-4 or 5+)	life. DO	kind of work done of NOT use retired) NOT use retired)				cal 43
d 2	led within Hygiene. other than ent, the N	Be	12th 17. Father's Name (First, Middle, Last)		00111			Name (First, Middle,		
ylan	should be file h and Mental H 7 is marked of raumatic evel	은	Leo Comotto					cy Danin		
Maryland 21215-0036	shoul h and l 7 is m trauma		19a. Informant's Name/Relationship (Type, Pr	*				r Rural Route Numbe		
	l and 2 sl f Health a ftem 27 i		Rose Comotto /w 20a. Method of Disposition	20b. F	Place of Dispos	sition (Name of		ad Balti		D 21237 City or Town, State
imo	nit. Page artment or ortant: If injury or e.		1 X Burial 2 \square Cremation 3 \square Remo 4 \square Donation 5 \square Other (Specify)	val from State Ga	rdens	of Fai	th	4/4/12		ille MD
Baltimore,	permit. Page 1.8 Department of H Important: If its any injury or ot		21. Signature of Funeral Service Licensee	01111	22	Name and Addre		300 MAc	e Ave. ome of	Balto. M D Essex 21221
			23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cause	ns that caused the death se on each line.	h. Do not ente					Approximate Interval Between
-	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	METRITATIO		ON CANO	COR_			Ponset and Death
	Examiner		ſ	Due to (or as a consequ	uence of):					ľ
	e e	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ	uence of):					
	executed ian and urial-transit		Cause (Disease or injury that initiated events c resulting in death) Last	Due to (or as a consequ	uence of):					
00		Physician/Medical	d							
Box 68760	ath certificate be attending physic for use as the bu	/Mec	IF FEMALE:	ves, outcome of preana	nov	:				
XO.	eath ce attend	ician	in the past 12 months?	Live Birth 2 Feta Pregnant at time of c	al death 3 🗌	Ectopic pregnand Other (specify)	су		23d. Dai Mo	te of delivery nth Day Year
	that the death of the by the atter	Phys	9 Unknown	Unknown				-7		
s, P.O.	The law requires that the death certificate be take has been signed by the attending physic page 2 should be detached for use as the base.	by	Part II. Other significant conditions contribut	ing to death but not res	ulting in the ui	nderlying cause giv	ven in Part I.	i	obacco use contr Yes 2 No	ibute to the cause of death? 3 ☐ Probably 4 ☐ Unknown
ord	iw requals been 2 shou	Completed						24a. Was	an 24b. \	Were autopsy findings available orior to completion of cause of
Rec	The law cate has	Com						— autoj perfo 1 □ Yes	rmed?	death?
ital	sician, certifi lirector	o Be	25. Was case referred to medical examiner? 1 \(\subseteq \text{Yes} \) No	al:	55.40 · · ·	Oth	er'	Check only one)	. ,	
of/	Attending Physician: or death. ector: After this certific by the funeral director.	te: To	27. Manner of Death 28	1 Inpatient 2 a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury	4 ⊔ Nursir y at		dence 6 Other	
ion	tendir Jeath. tor: Af the fu	Certificate:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be			M 1 🗆	Yes 2 No			
Division of Vital Records,	al or At s after of I Direct of in by		4 Homicide determined 28	e. Place of Injury - At ho building, etc. (Specify,		et, factory, office		28f. Location (S City or Tow		er or Rural Route Number,
	To the Hospital or Attending Physician. The la within 24 hours after death. To the Funeral Director, After this certificate ha completely filled in by the funeral director, page	Medical	29a. Certifier (Check 2 Medical Examiner: Or	the basis of examination	n and/or investi	igation, in my opinic	on, death occur	red at the time, date a	ind place, and due	to the cause(s) and manner stated.
	To the within To the comple	Σ	only one) 3 Certifying Nurse Prace 29b. Signature and title of certifier	titioner: To the best of m	ny knowledge,	death occurred at t 29c. License		nd place, and due to t		nanner as stated. (Month, Day, Year)
	1 1		Muchael Ulu	Moch	MD	033	55/	,	4/2/	11
_	OW,		30. Name and address of person who completed MICHREL MERBA	ed cause of death (Item		Delphy	a Ro	#314, E	Batime	ue 21237
	Stat Registra	C	APR 0 3 2012 Serve	32 Registrar's Signat	ure	/				
			-							

Mark	E.	Constantine	

		1- For State Registrar	Cer	tificate of	Death	_		eg. No. 2	112	1022
Physicia ledical Examii	ın/	Decedent's Name (First, Middle,Last) Mark					2. Date of Dea Month March 25,	Day Year 2012		Time of Death 1612 hrs
		4a. Facility Name (if not institution, give str 355 Silver Run Valley Road	reet and number)	41	o. City, Town, o Westminst	r Location of De		4c. County o		
Funeral Director		5. Social Security Number 6. Sex 1 Number 6. Sex 1 Number 6. Sex 1 Number 6. Sex	7. Age (In yrs. la	ast birthday) Yrs.	If Under 1 Ye Months Day		vlin.	th(MM/DD/YYYY)	Foreign	ace (State or
21 be fill rked	To Be Completed by Funeral Director	1 X Never Married 2 Married 1 3 Widowed 4 Divorced lf Y	Road 2. Was Decedent Ever in U.S Armed Forces? Yes 2 X No es, Give Year Dates: ighest grade completed) College (1-4 or 5+) ne , Print) antine (Son) Removal from State	19b. Mailing. 326 S.	10f. Zip Code 1733 Decedent of H s, specify Cuba Yes 2\(\) No s Usual Occupa st of working life Carp Address (Stre Queen ion (Name of co	ispanic Origin? in, Mexican, Pue o specify: ation (Give kind e. DO NOT use Oenter 18.Mother's Na Nano et and Number St., AF	(Specify Yes or No orto Rican, etc.)	White Specify: 16b. Kind of Bus Const Maiden Surname) en	at Country A American , etc. Whit siness/indu ructi n, State, Zin , PA City or Tox	in Indian, Black, i.e. i.e. i.stry i.on p Code) 17340 wn, State
Zedo, cate be executed by sician and physician and the burial - transit		or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last UNPENDED IF FEMALE: 23b. Was decedent pregnant in the		Do not enter the	a mode of dying		ic or respiratory arr		rt A	CHAPEL , PA Approximate Interval Between Onset and Death Year
Division of Vital Records, P.C spital or Attending Physician: The law requires that hours after death. neral Director: After this certificate has been signed iffled in by the funeral director, page 2 should be deta	Medical Certification: To Be Completed by Physician/	past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions conditions 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined 29a. Certifier 1 Certifying Physician: (Check only one) 2 Medical Examiner:One)	Pregnant at time of deal Unknown Itributing to death but not re ital: 1	ER/Outpatient 28b. Time of Inj 1600 hrs	26. Plac 3 DOA ury 28c. Inju factory, office ad at the time, con, in my opinio	given in Part I. e of Death (Che Other Nu ury at Work? Yes 2 No building, etc.	23e. Did to 1 Yes 24a. Was autop perfor 1 Yes 25ck only one) rsing Home 5 28d. Describe I Subject driv 28f. Location (5 or Town, S 355 Silver Ru	bbacco use contrib 2 No 3 an 24b, W pr med? 2 No 1 Residence 6 how injury occurre er went off ro Street and Numbe state) n Valley Road, se(s) and manner	oute to the Probabl Probabl Probabl Pread and Probabl Other: Sold and and seld and seld and seld and seld and seld and seld (Month, seld and and seld (Month,	cause of death? y 4 Unknown sy findings available pletion of cause of 2 No cene struck trees Route Number, City ster, MD
St	ate	30. Name and address of person who composite Victor Weedn MD JD Assis 31. Date filed (Month, Day, Year)	pleted cause of death (Item stant Medical Examin 32. Registrar's Signatur	er 900 W.	Baltimore \$	Street, Baltir	more, MD 2122	23		
		ARR 0 0 2012 A		Made						

DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

OCAME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #10cod Per FH G926 4/03/2012 JH State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1 Month Physician/ Year 12:40 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Age (In yrs. last birthday) 8. Date of Birth

(Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** If Under 24 Hrs. Hours 62 Director 1 MM 2 D F Jan. 5, 1950 or 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland 10b Count 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 - XXXNo timore imore Gwynn Oak 10f. Zip Code 21207 10g, Citizen of What Country? 23a Funeral USA ıral", or items 2 Examiner mus 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☐ No Black, White, etc. þ 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Blac "natural", 3 Divorced 4 Divorced Completed Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DONOT use retired). 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) ecurit lears Be Father's Name (First, Middle, Last) Mother's Name (First, Middle_Maiden Sur ည Informant's Name/Belationship (Type 19b. Mailing Address (Street and Numb r or Rural Boute Number, City Health tem 27 Gwynn Oak. MD 20a. Method of Disposition 20b. Place of Disposition (N City or Town, State Department of H Important: If ite any injury or ot ■ Burial 2 □ Cremation 3 □ Removal from State MD4 Donation 5 Other (Specify) 21. Signarure of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Due to (or is a consequence of): nown Medical Examiner Sequentially list conditions, in any, reading to immediate cause. Enter Underlying Examiner e to (or as a consequence of) Cause (Disease or injury use as the burial-tran that initiated events resulting in death) Last pue Due to (or as a consequence of): by the attending physician Physician/Medical 68760 that the death certificate IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Box 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year filled in by the funeral director, page 2 should be detached Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed 23e. Did tobacco use contribute to the cause of death? ģ To the Hospital or Attending Physician: The law requires Diabetes 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Record Hypertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performe 2 No Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 🗌 Yes 2 မှ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Drath 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10053849 30. Name and address of person with completed cause of death (Item 23a) (Type, Print) tinore Maylond aini Avenue 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #8 Per FH G926 4/03/2012 JH State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 4:43PM Campbell Helen Medical City, Town, or Location of Death County of Death give street and number Examiner winas Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** (Month, Day, Y**1926** Director 1 □ M 2 🖼 -22-2013 items 23a or 28a-f show 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important if flem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10b City, Director 1 Yes 2 No MY 10g. Citizen of What Country? 10e. Street and Number Funeral 21117 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban Mexican, Puerto Rican, etc.) Was Decede it Ever in U.S Armed Forces? Race - American Indian 11. Marital Status Black, White, etc. 1 Newer Married 2 Married 2 No þ Yes : Baltimore, Maryland 21215-0036 1 Yes 2 No 3 ☑ Widowed 4 ☐ Divorced /ac Completed Year or Dates 16a. Decedent's Usual Occupation Give kind of work done during most of working the DO NOT use retired 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 400 Be 17. Father's Name (First, Middle, Last) ပ formant's Name/Relationship (Type, 19b. Mailing Address 20b. Place of Disposition (Name of pemetery, crematory or other place, 20a. Method of Disposition Page 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signat / e of Funeral Service Licensee MO 21133 a 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between End-Stare Dementia Onset and Death Immediate Cause (Final disease or condition Physician. Medical resulting in death) Due to (or as a conse uence of): Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be exec attending physician Physician/Medical P.O. Box 68760 use as the IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) signed by the at 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed plnous 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy completely filled in by the funeral director, page 2 performed? Yes 2 No hours after death.

uneral Director, After this certificate 25. Was case referred to medical 26. Place of Death (Check only one) Medical Certificate: To Be examiner? Other: 4 🗌 Nursing Home 5 🗷 Residence 6 🗌 Other (Specify) 1 Tes 2 🗷 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural injury 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie nsnajapaknemo 29c. License number 00057465 3/30/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SRAJAPAICH MD Baltimore MD 21209 5703 31. Date filed (Month, Day, Year, 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 21:50 Conle Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death University of Manyland Medical Ba ('enter Himore 8. Date of Birth (Month, Day, Year) Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 219-26-5234 Hours Director 1 X M 2 🗆 F 0 1939 West Virginia 28. at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified 28a-f 1 Yes 2x No Maryland Harford Joppa o 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a USA 1308 Blossom Drive 21085 items filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. or . þ 1 Never Married 2 🙀 Married 1 ☐ Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. "natural", 3 Widowed 4 Divorced Completed White Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Construction Carpenter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental I ပ Martha Myrtle Myers Cecil Dennison Conley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1308 Blossom Drive, Joppa, Maryland 21085 of Health Eileen Conley / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State eemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Bel Air, Maryland Rose Hill Svcs, LLC 4-6-2012 Signature Fineral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition Onset and Death Ph_sician/ 61 now Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): as the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: use yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ò in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) been signed by the a should be detached 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 1 Tes 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has autopsy perform 2 XN Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No ဂ 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this completely filled in by the funeral 27. Manner of Death Date of injury (Month, Day, Year) 28c. Injury at work? 1 Yes 2 No Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury death. 2 Accident
3 Suicide Investigation within 24 hours after deat To the Funeral Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) s of person who completed cause of death (Item 23a) (Type, Print)

Registrar

Gupta

31. Date filed (Month, Day, Year)

32. Registrar's Signature

12-02186

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Nicholas C Cole	State of Maryland / Department of Health and Mental Hygiene amend #9,11,12,15, Longitude of Death Per ANA BD G926 4/03/2012 JH Registrar	023
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,Last) 2. Date or Deatn S. Ilme of Month Day Year	
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Annapolis 4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number unl 6. Sex 17. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (Starting Months Days Hours Min. Aug 12, 1941 Country Lou	
any	Usual Residence of Decedent 10a, State 10b, County 10c, City, Town or Location 10d, Insid	e City Limits
▶		es 2 📉 No
the Maryland a or 28a-f sh officed at once	10e. Street and Number 639 Bywater Rd. 10f. Zip Code 21401 USA	
imore, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Reath and Mental Hygiene. Tant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatte event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	2 3 Williamed 4 Divolocal Total	
5-0036 ed within 72 hours afti stygiene. other than "natural" the Medical Examine Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) College 12 College 13 College 14 College 15 College 15 College 16 College 16 College 17 College 17 College 17 College 18 College 18 College 18 College 19 College 19	
5-0036 ed within ygiene. other tha he Medic	unk 12 unk 1 Social Security 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unk	rumin.
21215 ald be file Mental H Marked of event, th	Filiott Cole Edith Robertson	r)
MD 2 12 shoul th and N 127 is m	Timothy Cole-Bröther 900 W. Baltimore St; Baltimore, MD 21201	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygene. Important: If item 27 is marked other than injury or other transmatte event, the Medical Injury or other transmatters and the Med	20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 20b. Place of Disposition (Name of cernetery, crematory or other place) 20c. Location - City or Town, State	
altim mit. Pag Sartment portant: ury or o	4 Donation 5 Other Specify: in State Atlantic Crematory 3-29-2012 Glen Burnie. M 21. Signature of Fuce Service Licens Ronald S Director 22. Name and Address of Facility State Anatomy Board Simplicity Cremation and Funeral Services Simplicity Cremation and Funeral Services Anatomy Board Services Simplicity Cremation and Funeral Services Anatomy Board Services Simplicity Cremation and Funeral Services Anatomy Board Services Anatomy	D
	23a Part Finter the disease or complications that caused the death. Do not enter the mode of long, such as cardiac or respiration arrest, shock, or heart Approxi	mate Interval
Physician /Medical Examiner	failule List only one cause on each line.	en Onset and Death
_xammer	or condition resulting in death) Due to (or as a consequence of): b. Hypertensive Atherosclerotic Cardiovascular Disease	
iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause c.	
uted nd ransit Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.	
D, be executed sician and ourial - transi	22 d Date of delivery	
P.O. Box 68760, that the death certificate be executed ned by the attending physician and detached for use as the bunal - transit by Physician/Medical EX	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify) 9 Unknown	Year
O. B. at the de lached for a Physical P		
cords, P.C. law requires that has been signed should be deta noted by	chronic alcohol abuse 1 Yes 2 No 3 Probably 4 1 24a. Was an 24b. Were autopsy finding	
Division of Vital Records, P.O. all or Attending Physician: The law requires that the start clearh. a) Director: After this certificate has been signed by led in by the funeral director, page 2 should be detact bertification: To Be Completed by F	autopsy prior to completion performed? 1 ✓ Yes 2 No 1 ✓ Yes	of cause of
al Re m: The entificate stor, pag	25. Was case referred to medical	
of Vital Recing Physician: The After this certificate Tuneral director, page 70 mirror 10 Be Con	1 V Yes 2 No 1 Inpatient 2 Erroutpatient 3 Box 4 Injury 128d Describe how injury occurred	
lon o tending sath. or: Aft the fund	1 Natural 5 Pending 2 Accident Investigation (Month, Day, Year)	
Division or spital or Attending nours after death. nerral Director: After filled in by the func Certification:	28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide 4 Userside 4 Userside 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	Number, City
Division of Vital Rec To the Hopital or Attending Physician: The I within 24 hours after death. To the Funcral Director: After this certificate I completely filled in by the funeral director, page)
or February Page		'ear)
	O.C.M.E. March 17, 2012	
3)	30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	
State Registra		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Richard curnutte 3:00 AM 63 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death UNION MEMORIAL HOSPITAL N/A BALTIMORE CITY Social Security Number Age (In yrs. last birthday) if Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 1 ₹ M 2 □ F Director 137-24-6819 82 7/8/1929 PENNSYLVANIA 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD BALTIMORE MIDDLE RIVER 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21220 31 GYRO DRIVE USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces? 1 X Yes 2 □ No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2X Married Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: 3 Widowed 4 Divorced WHITE Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) HARFORD CARPET Elementary/Secondary (0-12) College (1-4 or 5+) 12TH GRADE WAREHOUSE FOREMAN SERVICES Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ၉ HANCEFORD CURNUTTE BESSIE PERRY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DORIS CURNUTTE/WIFE 31 GYRO DRIVE MIDDLE RIVER. 21220 MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) 4/4/12 HOLLY HILL MEM. GARDENS MIDDLE RIVER, MD 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, MO1139 TOWSON, MD 21286 Approximate Interval Between Onset and Death
2 months Immediate Cause (Final Physician/ interstitial luna disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** 2 weeks pneumoma Sequentially list conditions he to for as a consequence of cause. Enter Underlying Exami Cause (Disease or injury that initiated events law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Medical Division of Vital Records, P.O. Box 68760 attending place as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown signed by tall Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of has death? Hospital or Attending Physician: The After this certificate 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 2 X No 1 Yes မ 1 X Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No n 24 hours after death.

Referral Director: A pletely filled in by the fi Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 1 🏿 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certif 29d. Date signed (Month, Day, Year) AT 243 8946 B5 31 3 2012 - MD

State

PKWU

Baltimore, mo

university

32. Registrar's agnatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 12-02502 State of Maryland / Department of Health and Mental Hygiene William Durgin 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day March 28, 2012 1930 hrs Durgin William Barry Medical Examiner 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Baltimore County** Lutherville Timonium 41 Blondell Court 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 24Hrs. 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number 6. Sex **Funeral** Months Days Hours Min. Nov 3 1946 Country) Director 220-46-7637 65 1 X M 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 Yes 2 No Baltimore Timonium 28a-f show mit. Pages I and 2 should be filed within 72 hours after death with the Maryland partment of Health and Mental Hygiene.

portant: If item 27 is marked other than "natural", or items 23a or 28a-f sho jury or other traumatic event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21093 USA 41 Blondell Court 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. Armed Forces? 1966 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 X Married 1X Yes Ng 972 1 Yes 2 X No specify: Specify: white Yes, Give Yeer 3 Widowed 4 Divorced ੬ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) construction 21215-0036 roofing engineer 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Olga Isaacs Charles Bernard Durgin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 29465 Glenwood Dr., Millsboro, DE 19966 Mrs. Klarissa Durgin (spouse) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Baltimore, crematory or other place) 1 ABurial 2 Cremation 3 Removal from State Garrison Forest Vet. 4 - 3 - 12Owings Mills, MD 4 Donation 5 Other Specify: 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee P.O. Box 195 Sykesville, MD 21784 & toppost of Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line /Medical Death a Neck Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed y the attending physician and shed for use as the burial - tra Physician/Medical UNPENDED AMENDED Box 68760, 23d. Date of deliver 23c. If yes, outcome of pregnancy Year Day 23b. Was decedent pregnant in the 1 Live birth Fetal death 3 Ectopic pregnancy Month 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. signed by 1 Yes 2 No 3 Probably 4 Vunknown 虿 Hypertensive cardiovascular disease, chronic alcohol abuse Completed 24b. Were autopsy findings available 24a, Was an certificate has been prior to completion of cause of autopsy performed? death? Yes 2 No 1 🗸 Yes 26 Place of Death (Check only one) 25. Was case referred to medical funeral director, Division of Vital Other Nursing Home 5 Residence 6 Other: Scene Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA After this 1 Yes 28d. Describe how injury occurred 28a. Date of Injury (Month, Day,Year) FOUND: 28c. Injury at Work? 28b. Time of Injury 27. Manner of Death Subject fell down stairs in home FOUND: 1 Yes 2 ✓ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fur 1 Natural Pending Mar 28, 2012 1900 hrs 2 🗹 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Suicide Could not be or Town, State) 41 Blondell Court, Lutherville Timonium, MD determined (Specify) Residence Homicide 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Windical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar DHMH 17 Rev 1/2001

OCME 2006

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

March 29, 2012

29b. Signature and title of certifier

Melissa Brassell, MD

31. Date filed (Month, Day Ye

and manner stated

32. Registrar's Signatur

30. Name and address of person who completed cause of death (Item 23a)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Middle, Last) s Name (First, 2. Date of Death Physician/ Month 1:23 AM auer Marci Medical me (if not institution, give street and nur **Examiner** 4b. City, Town ishington M More 7/en Social Security Number Age (In yrs. last birthday) If Under If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** ^{Year)} 1932 Months July 8, Arizona 527-36-3776 **Director** 79 1 M 2 X F Usual Residence of Deced 28a-f show 10c. City, Town or Location notified at 10a. State 10b. Count 10d. Inside City Limits Director MD Anne Arundel Millersville 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be 23a Funeral 8373 Gartelman Farm Drive 21108 USA items Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Examiner Armed Force Black, White, etc. 0 þ 1 Never Married 2 Married 1 Yes 2X No If Yes, Give Year or Dates. 3altimore, Maryland 21215-0036 within 72 hours after 1 X^{Yes} 2 \square No Specify: Spanish/Mexican Specify: White 'natural", Completed 3 X Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Waitress Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I ပ Robert Rito Duke Poncianna Rose Rubio traumatic 19a. Informant's Name/Relationship (Type, Print) Laye 1 and 2 since partment of Health an Important; If item 27 is n any injury or other Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co. Alisa Michele Dauer/daughter 8373 Gartelman Farm Dr. Millersville, MD 21108 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State Final Journey Crematory 04/03/12 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funcial Service 22. Name and Address of Facility
Soing Home Cremation Service P.O. Box 784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Clarksville MD 21029 Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ metastatic disease or condition resulting in death) cancer Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, is a problem of the cause. Enter Underlying Cause (Disease or injury Examiner Date to live as a cympa-viance ofe and that initiated events resulting in death) Last Due to (or as a consequence of): burial physician a Physician/Medical requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) for in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death the Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has perform 2 No Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 Tyes 2 မ 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, Funeral Director: After this stely filled in by the funeral di Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 5 Pending after death. 1 Yes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 3 29h. Signature and title of certifier 0

DHMH 17 Rev 06-2011

State Registrar completed cause of death (Item 23a) (Type,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dr Zemecki Month Day Year Physician/ Shirley 11: OUA M APM 2 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3118 Whiteway Road Edgemere Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours June 30, 1934 Maryland 212-30-1261 Director 1 🗆 M 2 🛣 77 Usual Residence of Dec 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Md. Baltimore Edgemere 1 🗌 Yes 2 🄀 No or 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 3118 Whiteway Road within 72 hours after death with 21219 USA "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🏿 No If Yes, Give þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: 3X Widowed 4 ☐ Divorced Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumation. Elementary/Secondary (0-12) College (1-4 or 5+) Housewife Own Home 11 years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Robert E. Bailey Elsie M. Warfield 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna Foulke 3118 Whiteway Road, Edgemere, Md. 21219 Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Aprilie 4, 1 🗶 Burial 2 🗌 Cremation 3 🗀 Removal from State Dundalk, Maryland Sacred Heart of Jesus 2012 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Servin 22. Name and Address of Facility Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. mo1176 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Gall bladder Cancer disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Dusito (or as a consequence of): if any, leading to mimediate cause. Enter Underlying Cause (Disease or injury that initiated events sician and burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending phase as t IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Live ta. Co. in the past 12 months? Month Day Year ed by the a detached f Yes 2 No g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After t completely filled in by the funeral 1 Natural work? 1 \(\subseteq \text{Yes} 5 Pending 2 🗌 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 2 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier pathenn 00057465 57B Balhmore MD 21205 15 Knj

Registrar DHMH 17 Rev 06-2011

State

Smith

Day

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NSRAPA ISEMD 2835 SMNh AV

31. Date filed (Month, Day, Year)

3 2012

2835

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ APRIL 10:45AM Richard C. Davis Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** County of Death OWSOV MEDICAL CENTE Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) **Funeral** Months 220**-**20**-**5217 Hours Director 1 🕅 M 2 🗆 F 84 May 1, 1927 Maryland show 10c. City, Town or Location 10d. Inside City Limits the Maryland items 23a or 28a-f sho er must be notified at Director Maryland Baltimore Phoenix 1 Yes 2 X No 10f. Zip Code 10g. Citizen of What Country? Funeral permit. Page 1 and 2 should be filed within 72 hours after death with 13400 Cambria Farms Road 21131 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Argred Forces?

1 Yes 2 If Yes, Give 0 Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White "natural" 3 X Widowed 4 Divorced Navv Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Health and Mental Hygiene. tem 27 is marked other than Elementary/Secondary (0-12) Chairman of the Board Bank One, WV Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Stanley Davis Lillian Schimmel1 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John R. Davis / Son 13400 Cambria Farms Rd. Phoenix, Md. 21131 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State of Fi 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Department or Important: If any injury or Hilltop Service Corp. 4/3/2012 4 Donation 5 Other (Specify) Towson, Maryland Signature of Planeral S 22. Name and Address of Facility 1050 York Road Earl L. Canapp Ruck Towson Funeral Home, Inc. Towson, Md. 21204 23a. Part 1. Enter the e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart and Immediate Cause (Final . List only one cause on each line Physician/ disease or condition resulting in death) Medical RUCTIVE PULMONARY DISEASES VEARS Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death Other (specify) 1 Yes 2 9 Unknown 2 🗌 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 X No Hospital: Other: ၉ Inpatient 2 ER/Outpatient 3 DOA 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c, Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural iniury 5 Pending Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29c. License number 29d. Date signed (Month, Day, Year) M

Registrar DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

0 3

Name and address of person who completed cause of death (Item 23a) (Type, Print

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#20b, perFH, G926,4/3/2012 WS
State of Maryland / Department of Health and Mental Hygiene
State amend item 20b per fh g926 4-5-12 vt
Certificate of Death

Reg. No. 20 2 edent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2:58 P.M oroth Medical March 4a. Facility Name (if not institution, give street and number) Town, or Location of Death **Examiner** 4c. County of Death teu Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth (Month, Day, Ye Birthplace (State or Foreign Country) **Funeral** Months Hours Min Director 1 🗆 M 2 🖼 8-15-1930 g ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at filed within 72 hours after death with the Maryland al Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** Himore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21229 USA Kossutt 11. Marital Status Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces? þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give Black 3 ₩Widowed 4 □ Divorced Completed Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 72 alth and Mental Hygiene. Elementary/Secondary (0-12) Callege (1-4 or 5+) erK year Be 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname) ပ Hebran gera Informant's Name/Relationship (Type, dress (Street and Number or permit. Page 1 and 2 st Department of Health at Important: If item 27 is any injury or other tran-1913 oreen gage 20b. PME of DZion (Gemeter) 20a. Method of Disposition 20c. Location -City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Baltimore, SMD 4 Donation 5 Other (Specify) reene Funeral Services re of Funeral Service icense National Pike (21229) Baltimore 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Due to (or as a consequence of): Vosedlar disease or condition COMMAN Medical resulting in death) Examiner Sequentially list conditions, if any Leading to Immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to or as a consequence of that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Be Completed by Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav 5 Other (specify) the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hypertensian Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy performed Yes 2 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: ၉ 1 Tes 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of De th Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural 5 Pending injury Accident Investigation M 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10055849 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 Faint Agnes 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 0 3 2012 Registrar

Physiciar /Medica Examine

Funeral Director

Physician

State Registrar						C	Pertifica	ate of	Death				Reg. N	No. 2	20	12	der cit-rinea	024
I. Decedent's Na	me (First, Midd	lle, Lasi	t)									Date of D Month		Day	Ye	ear	3. Tin	ne of Death
ARTHUR												ARCH	30,	201			020	0 M
la. Facility Name					_				or Location	of Death	n		1	4c. Cou	unty of I	Death		
F KANKL	IN WOOL	6. Se		7. Age (ast birtho		OSEDA der 1 Year		24 Hrs.	8.	Date of Bi	rth			BAL'		ate or Foreign
213-30-	0869	1[X M 2□ F	78	3	Yrs	s. Month	s Days	Hours	Min.		(Month, D		,		Couir MA	ntry) RYLA	NTD.
Jsual Residence	of Decedent			14	0- 01-	T						ML 1	V 9 I .	1.1.1				
MD .	10b. Count	y BALT	0		uc. City,		r Location	TC .								1	10d. Inside City Limits 1 ☐ Yes 2 ☐ No	
I Oe. Street and N			· · · · · · · · · · · · · · · · · · ·	Tillux.				10f. Zip Code			10g Citizen of Wh			of Who				
		TENIT	17				101. 4				10g. Citizen of Wha			,				
			12. Was Decedent Ever in U.S. Armed Forces? 1 ▼Yes 2 No			S.	21234 13. Was Decedent of Hispanic Origin?			igin? (Sı	pecify	Yes or N	0-	14.	USA Race -		an India	n,
							If Yes, s	If Yes, specify Cuban, Mexican, Puerto I			to Rica	an, etc.)			Black, \	White,	etc.	
3 Widowed	4 ☐ Divorce	d	If Ye s, Gi Year or D				1 ∐ Yes	2 No	Specify					Spe	ecify:	WI	HITE	
(St	15. Decede pecify only high	nt's Edu	ucation de completed)			(0	ecedent's U	work done	during mo.	st of wor	rking		16b.	Kind o	of Busin	ness/In	dustry	
	condary (0-12)		College (1-4or 5+)		`li	fe. DO NOT	use retire	ed)		0							
12T 17. Father's Nam		l ast)					POSTA	L CAR		er's Nam	ne (Fi	rst, Middle			OFF	EICI	Ξ	
ARTHUR															namej			
19a. Informant's			vpe. Print)			19b. N	failing Addre	ess (Street				E BU			own. Sta	ate. Zir	Code)	
MADA D	T. (10) T. (1)							,							,	, ,	,	
MARY DISTEFANO SPOUSE 8812 BAKER AVENUE PARKVILLE MD 212 20a. Method of Disposition (Name of Date 20c. Location - City																		
20a. Method of Disposition 1 Purial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) HOLY ROSARY CEM. 20c. Location - City of Cemetery, crematory or other place) HOLY ROSARY CEM.									1	I	PAR Date	KVIL	E 20c.	MD .	21 on - Cit	234 ty or To	own, Sta	'e
20a. Method of D 1 ☐ Burial	isposition 2 Cremation	3 🗆 1	Removal from		20b. Pl	lace of Demetery,	isposition (A	vame of or other pla	1									e
20a. Method of D 1 B urial 4 Donation	isposition 2 □ Cremation n 5 □ Other (3 □ I Specify	Removal from		20b. Pl	lace of Demetery,	crematory of OSARY	vame of or other pla	ace)	4–3-	-20	12	DUN	IADI	LK,	MD.	•	
20a. Method of D 1 B urial 4 Donation	isposition 2 □ Cremation n 5 □ Other (3 □ I Specify	Removal from		20b. Pl	lace of Demetery,	isposition (A crematory of OSARY 22. Name	CEM.	1	4-3-	-20 HIM	12	DUN	NDAI NERA	LK,	MD .	E, II	NC.
20a. Method of D 1 Burial 4 Donation 21. Signature of D 23a. Part1. Enter	isposition 2	3 □I Specify e Licens	Removal from) see	State	HO	lace of Demetery,	osposition (A crematory of OSARY) 22. Name	CEM. and Addre	ess of Facil	4-3- ity SCE ROA	-20 HIM AD	12 UNEK NOT	DUN FUN CINC	NDAI NERA	LK,	MD .	2123	NC. 36
20a. Method of D 1 Purial 4 Donation 21. Signature of D 23a. Part1. Enter shook, or h Immediate Caus	isposition 2	3 □I Specify e Licens	Removal from) see	State	HO	lace of Demetery,	osposition (A crematory of OSARY) 22. Name	CEM. and Addre	ess of Facil	4-3- ity SCE ROA	-20 HIM AD	12 UNEK NOT	DUN FUN CINC	NDAI NERA	LK,	MD .	Z, II	NC. 36
20a. Method of D 1 Furial 4 Donation 21. Signature of D 23a. Part1. Ente shock, or h Immediate Caus disease or condi	isposition 2	3 □I Specify e Licens	Removal from) see	State	e leath	lace of Demetery,	isposition (Acrematory of OSARY) 22. Name 9	CEM. and Addre	ess of Facil	4-3- ity SCE ROA	-20 HIM AD	12 UNEK NOT	DUN FUN CINC	NDAI NERA	LK,	MD .	Z, II	NC. 36 imate Between
20a. Method of D 1 Rurial 4 Donation 21. Signature of D 23a. Part1. Ente shock, or h Immediate Caus disease or condiresulting in death	isposition 2 Cremation 5 Other (Funeral Service or the usease of Failure 6 (Final tion)	3 □I Specify e Licens	Removal from) see	State	e leath	lace of Demetery, LY R	isposition (Acrematory of OSARY) 22. Name 9	CEM. and Addre	ess of Facil	4-3- ity SCE ROA	-20 HIM AD	12 UNEK NOT	DUN FUN CINC	NDAI NERA	LK,	MD .	Z, II	NC. 36 imate Between
20a. Method of D Description	isposition 2 Gremation 5 Other (Funeral Service or the sease of Failure 6 (Final tion) conditions, immediate	3 □I Specify e Licens	Removal from) see lications that the cause on Due to	State	HO HO	lace of Demetery, LY R	isposition (No. Command) (No.	CEM. and Addre	ess of Facil	4-3- ity SCE ROA	-20 HIM AD	12 UNEK NOT	DUN FUN CINC	NDAI NERA	LK,	MD .	Z, II	NC. 36 imate Between
20a. Method of D 1 Burial 4 Donation 21. Signature of Burnediate Cause disease or condiresulting in death Sequentially list if any, leading to cause. Enter Un Cause (Disease that initiated eve	isposition 2 Gremation 5 Gremation 5 Gremation funeral Servic or the sease e nailur e (Final tion n) conditions, immediate derlying or injury nts	3 □I Specify e Licens	Removal from) see lications that the cause on Due to	State cause 1 Iheach line. (or as a company of the company of th	HO HO	lace of Demetery, LY R	isposition (No. Command) (No.	CEM. and Addre	ess of Facil	4-3- ity SCE ROA	-20 HIM AD	12 UNEK NOT	DUN FUN CINC	NDAI NERA	LK,	MD .	Z, II	NC. 36 imate Between
20a. Method of D 1 Burial 4 Donation 21. Signature of Burnediate Cause disease or condiresulting in death Sequentially list if any, leading to cause. Enter Un Cause (Disease that initiated eve	isposition 2 Gremation 5 Gremation 5 Gremation funeral Servic or the sease e nailur e (Final tion n) conditions, immediate derlying or injury nts	3 □I Specify e Licens	Removal from) see Illications that one cause on a. Due to	State cause 1 Iheach line. (or as a company of the company of th	BO PICE HO	lace of Demoter of Demo	22. Name 25. Name 26. Name 27. Name 28. Name	CEM. and Addre	ess of Facil	4-3- ity SCE ROA	-20 HIM AD	12 UNEK NOT	DUN FUN CINC	NDAI NERA	LK,	MD .	Z, II	NC. 36 imate Between
20a. Method of D 1 Purial 4 Donation 21. Signature of Shock, or h Immediate Caus disease or condiresulting in death Sequentially list if any, leading to cause. Enter Un Cause (Disease that initiated eve	isposition 2 Gremation 5 Gremation 5 Gremation funeral Servic or the sease e nailur e (Final tion n) conditions, immediate derlying or injury nts	3 □I Specify e Licens	Removal from) see Illications that one cause on a. Due to	State cause in the each line. (or as a coordinate of the coordin	BO PICE HO	lace of Demoter of Demo	22. Name 25. Name 26. Name 27. Name 28. Name	CEM. and Addre	ess of Facil	4-3- ity SCE ROA	-20 HIM AD	12 UNEK NOT	DUN FUN CINC	NDAI NERA	LK,	MD .	Z, II	NC. 36 imate Between
20a. Method of D 1 Purial 4 Donation 21. Signature of Shock, or h Immediate Caus disease or condiresulting in death Sequentially list if any, leading to cause. Enter Un Cause (Disease that initiated everesulting in death	isposition 2 Gremation 5 Gremation 5 Gremation funeral Servic or the sease e nailur e (Final tion n) conditions, immediate derlying or injury nts	3 □I Specify e Licens	Removal from) see Illications that one cause on a. Due to Due to Due to	State cause: The each line. (or as a coordinate of the co	e feath conseque	Lace of Demoter of Person	22. Name 25. Name 26. Name 27. Name 28. Name	CEM. and Addre	ess of Facil	4-3- ity SCE ROA	-20 HIM AD	12 UNEK NOT	DUN FUN CINC	NDAI NERA	LK,	MD .	Z, II	NC. 36 imate Between
20a. Method of D 1 Purial 4 Donation 21. Signature of Shock, or h Immediate Caus disease or condiresulting in death Sequentially list if any, leading to cause. Enter Un Cause (Disease that initiated everesulting in death	isposition 2 Gremation 5 Other (Funeral Service the sease to railly the conditions, immediate derlying or injury nts ent pregnant	3 □I Specify e Licens	Removal from) see Illications that one cause on the cause of the cau	cause the cause	e leath consequences	lace of permeter N R R R R R R R R R R R R R R R R R R	22. Name 25. Name 26. Name 27. Name 28. Name	vame of or other plan CEM. and Addre 705 B node of dyi	ess of Facil	4-3- ity SCE ROA	-20 HIM AD	12 UNEK NOT	DUN FUN CINC	NDAI NERÆ CHAN	LK, AL H	MD.	Approximately and a second consection of the s	NC - 36 imate I Between and Death
20a. Method of D 1 Purial 4 Donation 21. Signature of D 23a. Part1. Ente shock, or h Immediate Caus disease or condiresulting in death Sequentially list if any, leading to cause. Enter Urcause (Disease that initiated everesulting in death	isposition 2	3 □I Specify e Licens	Removal from) see Illications that one cause on the cause of the cau	cause the ach line. (or as a compared to a	e leath consequences	lace of permeter N R R R R R R R R R R R R R R R R R R	isposition (No. Command) (No.	wame of protection of the plane	ess of Facil	4-3- ity SCE ROA	-20 HIM AD	12 UNEK NOT	DUN FUN CINC	NDAI NERÆ CHAN	LK, AL H	MD.	E, III 2123 Approx Interva	NC. 36 imate Between
20a. Method of D 1 Burial 4 Donation 21. Signature of Shock, or h Immediate Cause disease or condiresulting in death Sequentially list if any, leading to cause. Enter Un Cause (Disease that initiated everesulting in death	isposition 2	3 Till Specify Betternstation	Removal from) see Ilications that one cause on a. Due to Due to Due to 23c. If yes, ou 1 Live 4 Preg 9 Unkr	cause the ach line. (or as a compared of the	e leath consequences	Lace of Demeter Remeter Remete	isposition (No. Command) 22. Name 22. Name 3. Ectopic 5. Other	rother plane of the property of the plane of	ess of Facilists o	4-3- ity SCE ROA s cardiac	-20 HIM AD	UNEK NOT	FUNC FINC arrest,	NDAI NERAS GHAN 23d.	AL H	MD. HOME	Approximately and a series of the series of	NC . 36 imate Between and Death
20a. Method of D 1 Burial 4 Donation 21. Signature of Shock, or h Immediate Cause disease or condiresulting in death Sequentially list if any, leading to cause. Enter Uncause (Disease that initiated everesulting in death	isposition 2	3 Till Specify Betternstation	Removal from) see Ilications that one cause on a. Due to Due to Due to 23c. If yes, ou 1 Live 4 Preg 9 Unkr	cause the ach line. (or as a compared of the	e leath consequences	Lace of Demeter Remeter Remete	isposition (No. Command) 22. Name 22. Name 3. Ectopic 5. Other	rother plane of the property of the plane of	ess of Facilists o	4-3- ity SCE ROA s cardiac	-20 HIM AD	UNEK NOT'	FUNCTING arrest,	NDAI NERÆ GHAN 23d.	LLK, AL H 1, M Date c Month	MD. HOME	Approximatery Onset	Year
20a. Method of D 1 Burial 4 Donation 21. Signature of Shock, or h Immediate Cause disease or condiresulting in death Sequentially list if any, leading to cause. Enter Uncause (Disease that initiated everesulting in death	isposition 2	3 Till Specify Betternstation	Removal from) see Ilications that one cause on a. Due to Due to Due to 23c. If yes, ou 1 Live 4 Preg 9 Unkr	cause the ach line. (or as a compared of the	e leath consequences	Lace of Demeter Remeter Remete	isposition (No. Command) 22. Name 22. Name 3. Ectopic 5. Other	rother plane of the property of the plane of	ess of Facilists o	4-3- ity SCE ROA s cardiac	-20 HIM AD	UNEK NOT's espiratory	FUNC PINC arrest,	23d.	LLK, AL H 1, M Date of Month contribution 3	HOME OF delivery the control of the	Approximatery Onset	Year of death?
23a. Part1. Enter shock, or homediate Cause interest of any, leading to cause. Enter Uncause (Disease exhibiting in death at initiated every esulting in death of the cause. Enter Uncause (Disease exhibiting in death of the cause. Enter Uncause in the past 1 Yes 9 Unknown	isposition 2	3 Till Specify Betternstation	Removal from) see Ilications that one cause on a. Due to Due to Due to 23c. If yes, ou 1 Live 4 Preg 9 Unkr	cause the ach line. (or as a compared of the	e leath consequences	Lace of Demeter Remeter Remete	isposition (No. Command) 22. Name 22. Name 3. Ectopic 5. Other	rother plane of the property of the plane of	ess of Facilists o	4-3- ity SCE ROA s cardiac	-20 HIM AD	UNEK NOT' spiratory 23e. Did 1 24a. Wa	FUNC FUNC arrest,	23d.	LK, AL H 1, M Date contribution of the price of the pri	MD. HOME TO a of deliving the series of t	Approximatery and onset	Year
20a. Method of D 1 Rurial 4 Donation 21. Signature of D 23a. Part1. Ente shock, or h Immediate Caus disease or condiresulting in death Sequentially list if any, leading to cause. Enter Uncause (Disease that initiated everesulting in death FFEMALE: 23b. Was deced in the past 1 H yes 9 Unknown Part II. Other signature of the cause (Disease should be past 1 H yes 9 Unknown Part II. Other signature of the cause (Disease should be past 1 H yes 9 Unknown Part II. Other signature of the cause (Disease should be past 1 H yes 9 Unknown Part II. Other signature of the cause o	conditions, immediate deriying or injury nts 12 months?	3 Table 1 Specify 2 Specify 2 Specify 2 Strong 2	Removal from) see Ilications that one cause on a. Due to Due to Due to 23c. If yes, ou 1 Live 4 Preg 9 Unkr	cause the ach line. (or as a compared of the	e leath consequences	Lace of Demeter Remeter Remete	isposition (No. Command) 22. Name 22. Name 3. Ectopic 5. Other	rother plane of the property of the plane of	ess of Facilists o	4-3- ity SCE ROA s cardiac	-20 HIM AD	UNEK NOT' spiratory 23e. Did 1 24a. Wa	FUNCTING tobacc Yes	23d.	LK, AL H 1, M Date of Month Contribution 3	MD. HOME	Approximatery and onset	Year e of death? 4 29 Unknowrings available of cause of
20a. Method of D 1 Rurial 4 Donation 21. Signature of D 23a. Part1. Ente shock, or h Immediate Caus disease or condiresulting in death Sequentially list if any, leading to cause. Enter Un Cause (Disease that initiated everesulting in death IF FEMALE: 23b. Was deced in the past 1 Yes 9 Unknow Part II. Other signature of the past 1 Yes 1 Unknow 25. Was case reexaminer?	ent pregnant 12 months? 2 Cremation 15 Other (Fineral Service 17 Fineral Service 18 Fineral Service 19 Fineral Service 19 Fineral Service 10 Fineral Service 10 Fineral Service 11 Fineral Service 12 Fineral Service 12 Fineral Service 13 Fineral Service 14 Fineral Service 15 Fineral Service 16 Fineral Service 16 Fineral Service 17 Fineral Service 18 Fineral Service 19 Fineral Service 19 Fineral Service 10 Fineral Service 11 Fineral Service 11 Fineral Service 11 Fineral Service 12 Fineral Service 13 Fineral Service 14 Fineral Service 15 Fineral Service 16 Fineral Service 16 Fineral Service 17 Fineral Service 18 Fineral Service 19 Fineral Service 19 Fineral Service 10 Fineral Service 11 Fineral Service 12 Fineral Service 13 Fineral Service 14 Fineral Service 15 Fineral Service 16 Fineral Service 16 Fineral Service 16 Fineral Service 17 Fineral Service 17 Fineral Service 18 Fineral Service 18	3 Garage	Removal from) see Cations that one cause on a. Due to C. Due to Due to	cause the cause	e leath conseque pregnar Fetal ne of de	Lace of permeter v. R.	isposition (No. Corematory of OSARY) 22. Name 22. Name 3 Lenter the m 3 Lectopic 5 Other ne underlying	c pregnanc (specify)	ess of Facilities of Facilitie	4-3- ity SCE ROA ROA ROA I.	HIMAD ath (C	UNEK NOT' spiratory 23e. Did 1 24a. Wa author per 1 Yes sheek only	TUNC arrest, tobacc lyes s an opsy ormed 2	23d. o use 0 2 \(\text{N} \)	LK, LLK, Date of Month Contribution 3	MD. HOME TO a of deliving the deliving th	ery Day he cause bably ppsy find mpletion 2 \(\) No	Year e of death? 4 29 Unknowrings available of cause of
20a. Method of D Description	isposition 2 Cremation 5 Other (Fyneral Servic or the sease of Failure (Germation) conditions, immediate deriying or injury nts 12 months? 2 No wn Inflicant conditions ferred to medic	3 Garage	Removal from) see Cations that one cause on a. Due to Cations that one cause on a. Due to	cause The cach line. (or is a compared to the	e leath conseque pregnar Fetal ne of de	Lace of permeter v. R.	isposition (No. Corematory of OSARY) 22. Name 22. Name 3 Lenter the m 3 Lectopid 5 Other ne underlying attient 3 Lectopid 5 Lec	c pregnanc (specify)g cause gin	ess of Facilities of Facilitie	4-3- ity SCE ROA ROA ROA I.	HTM AD ath (C	UNEK NOT' spiratory 23e. Did 1 24a. Wa aut per 1 Yes heck only 5 Res	TUNC TUNC TUNC TUNC TUNC TUNC TUNC TUNC	23d. o use c 2 No	LLK, AL H 1, M Date c Month contribution 3	MD. HOME TO a of deliving the deliving th	ery Day he cause bably ppsy find mpletion 2 \(\) No	Year e of death? 4 29 Unknowrings available of cause of
20a. Method of D 1 Rurial 4 Donation 21. Signature of D 23a. Part1. Ente shock, or h Immediate Caus disease or condiresulting in death Sequentially list if any, leading to cause. Enter Un cause (Disease that initiated everesulting in death IF FEMALE: 23b. Was deced in the past 1 Yes 9 Unknown Part II. Other signature.	isposition 2	3 Table 1 Specify Control of the Con	Removal from) see Illications that one cause on a. Due to b. Due to c. Due to d. 23c. If yes, ou 1 Live 4 Preg 9 Unkr	cause The cach line. (or is a compared to the	e leath e leath conseque conseque pregnar Fetal ne of de	Lace of permeter v. R.	isposition (No. Crematory of OSARY) 22. Name 9. tenter the m 3 Ectopic 5 Other ne underlying attent 3 ne of	and Address of department of the properties of t	ess of Facilities of Facilitie	4-3- ity SCE ROA ROA s cardiac	HTM AD ath (C	UNEK NOT' spiratory 23e. Did 1 24a. Wa author per 1 Yes sheek only	TUNC TUNC TUNC TUNC TUNC TUNC TUNC TUNC	23d. o use c 2 No	LLK, AL H 1, M Date c Month contribution 3	MD. HOME TO a of deliving the deliving th	ery Day he cause bably ppsy find mpletion 2 \(\) No	Year e of death? 4 29 Unknowrings available of cause of

State Registrar

10

30. Name and addre

31. Date filed (Month, Day, Year)

Jude

Muneus

APR 0 3 2012

DHMH 17 Rev 1/2001

MD

Begistrar's Signature

ss of person who completed cause of death (Item 23a) (Type, Print)

D53462

DALWOOD ROOD Glen Purnie MD 21061

3/30/12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2^{Day} Physician/ 201^{Yea} April 1:30a Virginia Lee Davidson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 2824 Patapsco Rd. Finksburg Carroll Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) Hours 218-24-7766 80 Director Yrs 6-9-1931 MD or 28a-f show notified at with the Maryland 10a State 10b. County 10c. City, Town or Location 10d, Inside City Limits rector Carroll Finksburg MD 1 Yes 2 No ۵ 10e. Street and Number 10g. Citizen of What Country? ms 23a or must be n 10f. Zip Code Funeral USA 21048 2824 Patapsco Rd. ural", or items 2 within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married Yes 21 No Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: white "natural", Completed 3 X Widowed 4 Divorced Page 1 and 2 should be filed within 72 hours ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natur ury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Housewife 11 Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Ethel C. Royer Charles F. Switzer 19a. Informant's Name/Relationship (Type, Print) Daughtet 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 21048 Lori L. Davidson-Bell 2824 Patapsco Rd., Finksburg, MD Department of Health Important: If item 2; any injury or other to once. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Patapsco Cemetery: 4-6-2012 Finksburg, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility ${f F}$ e c er uneral fome Funeral Service Licenses 254 E. Main St., Westminster, MD Fart 1. Enter the disease, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events requires that the death certificate be executed and the burial-tran Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown be detached for Month Pregnant at time of death 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably Were autopsy findings available prior to completion of cause of 24a. Was an Hospital or Attending Physician: The law autopsy death? 1 ☐ Yes 2 ☐ No ☐ Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this nours after death.

neral Director: After this filled in by the funeral d 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural Natural injury work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours a Medical 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 hou

To the Funer

completely fi 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month Day, Year) (30: Name and address of person ted cause of death (Item 23a) (Type, Print) State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Eader Physician/ Month Year Carolyn 10'.15 AM March 2012 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore 1031 Green Hill Farm Road Reisterstown 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral Director** 212-44-5433 1 □ M 2 🗓 F 66 AUG 24, 1945 Tennessee Usual Residence of Decedent or 28a-f show notified at 10b. County 10a. State 10c. City, Town or Location Director 1 Yes 2 No Maryland Baltimore Reisterstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō event, the Medical Examiner must be Funeral 21136 USA 23a 1031 Green Hill Farm Road items Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. sant. If item 27 is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 ▼ No þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. If Yes, Give 3 🗌 Widowed 4 🔲 Divorced Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) AT&T Finance Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Villar Bennett Homer Manis traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1031 Green Hill Farm Road Reisterstown, MD 21136 Elliott Eader/husband other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ott once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Crest Lawn Memorial Garden's 4/4/2012 Marriottsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Haight Funeral Home & Chapel, P.A. P.O. Box 195 Sykesville, MD 21784 Jauna-Mc (410 - 795 - 1400)23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ cholangio carcinoma Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury attending physician and if for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death been signed by the s should be detached q 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 No prior to completion of cause of death?

1 Yes 2 No this certificate has funeral director, page 2 Be (25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DCA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: After t 28d. Describe how injury occurred 1 Natural injury 5 Pending the Hospies. It if it is a factor of the Funeral Director: Aft of the Funeral Director of the funeral part 2 Accident
3 Suicide
4 Homicide Investigation 6 \square Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Number Practitionar To the Certifying Investigation and the time of the cause (s) and manner at the (Check 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number nsRajapahrimo 00057465 4/2/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore MD 21209

DHMH 17 Rev 06-2011

State Registrar NSRajapaksemp

APR 0 3 2012

2835

SMITH AV

32. Registrar's Signature

5203

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 Physician/ March 29, Joseph С. Eshleman 8:00 \mathbf{P} M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Suburban Hospital Bethesda Montgomery Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral Director** 199-18-0514 1 🗶 M 2 🗆 F 83 Usual Residence of Decede May 22, 1928 Pennsylvania or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 No Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be 9918 Shelburne Terrace #208 20878 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. by 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify. WWII White 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Mechanical Designer Engineering Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F 2 Edwin Eshleman other traumatic Mary Byrnes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20878 ge 1 and 2 shart of Health a: If item 27 is <u>Joan F. Eshlem</u>an / Wife 9918 Shelburne Terrace #208, Gaithersburg, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Department of Important: If is any injury or or 1 Burial 2 XCremation 3 Removal from State $\overline{2012}$ 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium, Inc. Bethesda, Maryland 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. An M01360 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph i i n Lung Cancer disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or injury that initiated events Examine Due to (or as a consequence of): burial-trai Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death Yes 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? Yes 2X No 1 ☐ Yes 2 ☐ No Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 X No Other: 2 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 XNatural 5 Pending injury Division 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 E Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month. Day, Year) XI Du March 30, 2012 30. Name and address of person who impleted cause of death (Item 23a) (Type, Print) 8600 Old Georgetown Road, Bethesda, Maryland 20814 31. Date filed (M 3 2012 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Department of Health and Mental Hygiene
			State Registrar Certificate of Death Reg. No. 2012 024
П	Physicia		1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Bay Year 1. 52 PM
. Marine	Medic Examin		4a. Facility Name (if not institution, give street and number) 4b. City Town, or Location of Death 4c. County of Death
1			HCh MANDA CARE HOLAND PARK DALLINORE
4.	Funeral Director		5. Social Security Number 6. Sex 1 Nonth Page (In yrs. last birthday) 1 Nonth Page (
			Usual Residence of Decedent
	yland -f sho ed at	ctor	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Catonsville 10 Yes 2 🖔 No
	or 28a	Director	MD Baltimore Catonsville 1 □ Yes 2 🖾 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
	with the s 23a o	Funeral	6203 Ethel Ave 21228 U.S.A.
	death 'items nerm		11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
36	s after al", or Exami	Completed by	1 Never Married 2 Married 1 Yes 2 No 1 Yes 2 No Specify: Specify: Specify: Specify:
2-0	hours 'natur' dical I	olete	15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry
121	thin 72 ane. than '	Som	Elementary/Seconday (0-12) College (1-4 or 5+) life. DO NOT use retired)
d 2	led wi Hygie other ent, tl	o l	6th grade na Longshoreman Industries 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
/lan	d be fi Mental arked atic ev	욘	Lee W. Ferguson Vergie Smith
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: I fiem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6203 Ethel Ave, Catonsville, Md 21228
re,	and 2 Health tem 2 other 1		Freida Davis-Daughter 6203 Ethel Ave, Catonsville, Md 21228 20a. Method of Disposition (Name of Date Date 20c. Location - City or Town, State
mo	Page 1 nent of int: If i		1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Removal from State Cemetery, crematory or other place)
3alti	permit. I Departin Importa any inju		21. Signature of Fuperal Service Licensee M22 Name and Adores of Facility L
ш	<u></u>	2.5	23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate
	hysician/	100 mg	shock, or hear failure. List only one cause on each line. Interval Between the Poeth Course (Fig. 1)
1	Medical		disease or condition resulting in death) Due to (or as a consequence of):
	Examiner	Ţ.	Sequentially list conditions, b.
	ed sit	Examiner	if any, leading to immediate Due to (or as a consequence of): Cause (Disease or linjury
	execut in and ial-trar	Еха	that initiated events cresulting in death) Last C. Due to (or as a consequence of):
09	ath certificate be executed attending physician and for use as the burial-transit	dical	d
687	ding pl	/Me	IF FEMALE: 23b. Was decodent program: 23c. If yes, outcome of pregnancy
XO	attend I for us	ician	23b. Was decedent pregnant in the past 12 months? 1
P.O. Box 687	by the attached	Physician/Me	g 🗆 Unknown
<u>,</u>	v requires that been signed b should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
rds	requir been s	etec	1 Yes 2 No 3 Probably 4 Unknown
Records,	e has l	Completed	24a. Was an autopsy findings available autopsy prior to completion of cause of performed?
<u>а</u> .	rtificat		25. Was case referred to medical examiner?
Division of Vital	rhysic this ce al direc	욘	1
0	ding th. After	cate	27. Manner of Death 28a. Date of injury 28b. Time of injury 28c. Injury at work? 1
isio	Atten er dea ector: by the	Certificate:	3 Suicide 6 Could not be 4 Homicide determined determined determined and suit of the suit
2	urs aftural Dir		building, etc. (Specify) City or Town, State)
L	To the propriat or Artending Priysicant: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check conly one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
i i	No the	Σ	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
	10 cm		MARY 2-BOW CANP R158140 4/3/2012
	0811		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) U. 110 IIAN II - DABNES LANT 8819 WAILHAM Woods BI PARK U. 1/E. MD 2123
	Stat Registra	е	APR 0 3 2012 Central 32. Register's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death FLANAGAN Physician/ 2 OIZ EBORAH 1153 04 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Nov. 6,1956 Months Hours 020-48-5637 **Director** 1 🗆 M 2 🗐 🖡 55 MA or 28a-f show notified at 10b. County with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Edgewater 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a o must be Funeral 1431 East Central Ave. 21037 USA er than "natural", or items the Medical Exaπiner mu within 72 hours after death Was Deceus.
Armed Forces?
Vas 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black. White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working ntal Hygiene.
ed other than "
event, the Mec life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Self Employed Care Provider permit, Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth, any injury or other traumatic event, once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Robert Flanagan Evelen Duby 19a. Informant's Name/Relationship (Type: Print) ificant 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1431 East Central Ave. Edgewater, Maryland 21037 Joseph Richarson/ other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 🂢 Cremation 3 ☐ Removal from State Metro Crematory, Inc. 04/03/2012 | Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Furieral Service Licensee Stephanie 22. Name and Address of Facility Cremation Society of Maryland, Inc Custer 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner CARS Sequentially list conditions, Examine cause. Enter Underlying a consectience of To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or in that initiated events the burial-trai Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Be Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 2 No Yes 25. Was case referred to medica Be Other: 1 Yes 2 - No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending after death. 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral C

completely filled Medical 1-Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certi D21438

State Registrar

DHMH 17 Rev 06-2011

me and address of person who completed/cause of death (Item 23a) (Type, Print)

32. Registrar's Sig

HOWAROLIS MOLIYOI

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Katherine Garheart Louella 2012^{Year} March 28 1:01 a Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospice Dove House Westminster Carroll Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Days Hours 219-03-8025 93 Director 1 🗆 M 2 🗶 F July 8 1918 MD Usual Residence of Deced 28a-f show with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified Sykesville MD Carroll 1 Yes 2 No 10e. Street and Number "natural", or items 23a or edical Examiner must be n 10f. Zip Code 10g. Citizen of What Country? by Funeral 540 Streaker Road 21784 USA Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Completed 3 X Widowed 4 Divorced Specify: white Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry th and Mental Hygiene.
It is marked other than "r traumatic event, the Med (Give kind of work done during most of working College (1-4 or 5+) life. DO NOT use retired) Elementary/Secondary (0-12) LPN / postal clerk health care & USPS Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental F fitem 27 is marked or r other traumatic eve ဂ္ Martin Luther Groves Grace Gladfeltey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Guy Garheart II (son) 17 Gettysburg Ct., Littlestown, PA 17340 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State H i 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place, permit. Page Department of Important: If any injury or Brandenburg UMC Cem. 3-31-12 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Haight Funeral Home & Chapel Page Haight of FYBONNS P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physici_n disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** es Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery signed by the atter in the past 12 months
1 Yes 2 No Ectopic pregnancy Other (specify) Month Pregnant at time of death Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has I completely filled in by the funeral director, page 2.9 performed' 2 1 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 1 2 10 မ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 2 No 28d. Describe how injury occurred HOUSE Natural 5 Pending iniury Accident Investigation Suicide Could not be 3 ☐ Suiciae 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 0054218 30. Name and address of person who completed cause of death (Item 23a) (Type-Grint) & Malcalm chine, Westminster aman onth, Day, Year) 0 3 2012 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Day 2012 Physician/ David Lee Garrett March 23, 1914 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Columbia Howard Gilchrist Hospice 8. Date of Birth (Month, Day, Mar 17, Social Security Number If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, **Funeral** Hours Months Days 1949 **Director** Maryland 212-52-6895 1 X M 2 - F 63 Mar Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland notified at Funeral Director MD Howard Ellicott City 1 Yes 2 X No ō 10e. Street and Numbe 10f. Zip Code ms 23a or must be r 10g. Citizen of What Country? 21042 3152 St. John's Lane USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎇 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Examiner Black, White, etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: White "natural" Completed 3 XWidowed 4 Divorced Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the 12 Painter Home Improvements of Health and Mental Hygie If item 27 is marked other ir other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Howan S. Garrett Arnetta M. Mathias 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health a Jong Weon Kim/friend 3152 St. John's Lane Ellicott City, MD 21042 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Durial 2 Cremation 3 Removal from State injury or Department of Important: If any injury or 4 Donation 5 Other (Specify) Final Journey Crematory 04/03/12 Woodbine, MD Signature of Funeral Service Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deat Immediate Cause (Final Pnysician/ a Matostatic cholonois disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) attending physician and I for use as the burial-transit Due to (or as a consequence of): Physician/Medical or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Month Day Year been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 has performed. this certificate 1 Tes 25. Was case referred to medical filled in by the funeral director, To Be 26. Place of Death (Check only one) examiner? Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence \(\sum \) Other (Specify) \(\sum \) \(\sum \) 2 0 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: Magner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death.

To the Funeral Director: After 1 Natural 5 Pending 1 Yes 2 No Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only on 29b. Signatur and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

APR 0 3 2012

Coda

32. Registrar's Signature

lane

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 11:30 P M Nancy Grigg March Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Baltimore Timonium 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Min Director 10-24-15 Country) 238-60-7379 1 □ M 2 🔀 F 96 NC or 28a-f show iral", or items 23a or 28a-f shorex arminer must be notified at 10a, State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD NA Baltimore 1 Nes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 701 N. Arlington Avenue Apt. #609 21217 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decess? Armed Forces? ⁴ ☐ Yes 2 🔀 No 14. Race - American Indian. Black, White, etc. African Completed by 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates Maryland 21215-0036 1 Yes 2 No Specify. "natural" 3 X Widowed 4 Divorced Specify: American permit. Page 1 and 2 should be filed within 72 hour.
Department of Health and Mental Hyglene.
Important If Item 27 is marked other than "natur
any injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 6th Grade Meyerhoff Family Housekeeper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Garfield White Millie Thrower 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Greer-Daughter 1021 W. Lanvale Street Baltimore, Maryland 21217 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🔁 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) 04-05-12 Arbutus Mem. Pk. Arbutus, MD 21. Signature of Funeral Service - cen-Wylie Funeral Home P.A. 638 N. Gilmor Street Baltimore, Maryland 21217 23a. Part 1. Enter the disease, or condications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List one one cause on each line. Immediate Cause (Final Physician/ Onset and Death disease or condition CARDIOMYOPATHY Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) that initiated events physician and sthe burial-tran resulting in death) Last Due to (or as a consequence of). Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 X No Ectopic pregnancy for 5 Other (specify) Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performed? Yes 2 X No 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 X No Other: ٩ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred X Natural 5 Pending injury s after death. 2 No the Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
X Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TRACIE L. MORGAN, **CRNP** 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 Registrar

2012

GRIGG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2:25P Physician/ MARCH , 2012 Gladys A1ma Grube Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SAINT JOSEPH MEDICAL CENTER TOWSON BALTIMORE Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) Days Hours Min Director 090-22-9417 1 🗆 M 2 🗶 F 82 Usual Residence of Decedent May 28, 1929 New York show 10b. County 10c. City, Town or Location must be notified at 10d. Inside City Limits Director 28a-f Maryland Baltimore 1 Tes 2 X No Phoenix ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 1 Shanneybrook Court 21131 USA ral", or items? death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🗓 No Black, White, etc. þ 1 Never Married 2 Married filed within 72 hours after Maryland 21215-0036 If Yes, Give 1 Yes 2 No Specify: "natural". Completed 3 X Widowed 4 Divorced Specify: Year or Dates White the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 12 04 Home Manager Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file ည Gernannt other traumatic Gilbert A1ma Theis age 1 and 2 should sent of Health and N out. If item 27 is ma y or other trauma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Craig A. Grube/Son 844 South Atlantic Ave., Virginia Beach, VA 23451 altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 cemetery, crematory or other place) 4/2/12 permit. Page Department o Important: If any injury or Dengtion 5 Other (Specify Dulaney Valley Memorial Gardens Timonium, Maryland 2 Signature of Funeral Service en Bryan W. Clary 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley Inc. 10 W. Padonia Road, Timonium, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line.

Immediate Cause (Final RESPIRATION FATTURE) Approximate RESPIRATORY FAILURE Physician/ 24 HOURS disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner 24 HOURS SEPSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underl, in Cause (Disease or injury Due to (or as a consequence of): Exami YEARS PULMONARY HYPERTENSION sician and burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical that the death certificate be 68760 attending p IF FFMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day 5 Other (specify) Pregnant at time of death Month Year 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CONGESTIVE HEART FAILURE To the Hospital or Attending Physician: The law requires Records, 1 Yes 2 No 3 Probably 4 Unknown CHRONIC KIDNEY DISEASE 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an has performed? Yes 2 No of Vital To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending injury Division Accident Investigation within 24 hours after deat To the Funeral Director: completely filled in by the 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At hor building, etc. (Specify) At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) D0053464 03/30/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TOWSON, MD 21204 MARX.M 7601 OSLER 32. Registrar signatur State Registrar

DHMH 17 Rev 06-2011

DHMH 17 Rev 1/2001 OCME 2006

Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 31^{Day} Edward Bartlett Hinebaugh March 2012 6:10 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Catonsville Charlestown Care Center Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Country) Maryland 1 ▼M 2 □ F Months Days Hours Min. July 25 97 Ye1'914 218-10-4277 **Director** Usual Residence of Decedent 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County 10c. City, Town or Location 10d. Inside City Limits Director be notified Baltimore Catonsville Maryland 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21228 United States ed other than "natural", or items 233 event, the Medical Examiner must I 709 Maiden Choice Lane 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 X Yes 2 No
If Yes, Give 1941 Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 1945 White Specify: 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Accountant Hardware Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Gracia Bartlett Arthur Hinebaugh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5320 Winter Moss Ct., Columbia, Maryland 21045 Ronald P Hinebaugh/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1
Department of Important: If it any injury or o once. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc 04/02/2012 Baltimore, Maryland 21. Signature of Funeral Service Licensee Alvson K Taylor 22. Name and Address of Facility Cremation Society of Maryland Inc 299 Frederick Road, Baltimon 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 299 Frederick Road, Baltimore, Maryland 21228 Interval Between Onset and Death Immediate Cause (Final Ph si ian/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events burial-tran Due to (or as a consequence of) resulting in death) Last physiciar Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending IF FEMALE: nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death Ectopic pregnancy in the past 12 mor for Month 5 Other (specify) yes 2 No 9 ☐ Unknown Pregnant at time of death detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 ■ No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, to 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4. Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manne Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work?
1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29d. Date signed (Month. Day. Year) 30. Name and address of per on who completed cause of death (Item 23a) (Type, Print) Catonsville chael Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. redent's Name (First, Middle, Last) Date of Death 3. Time of Death Physician/ WRI Medical **Examiner** 4c. County of Death If Under 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral Director** 1**X** M 2 □ F 66 Yrs. 03-09-28a-f shov 10a, State 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland 10d. Inside City Limits Examiner must be notified at Funeral Director MDBALTIMORE 1 ¥ Yes 2 ☐ No ò 10e. Street and Number 10g. Citizen of What Country? 23a US4 21218 GONNE Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc 1 Never Married 2 Married "natural", or Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: BLACK 3 Divorced 4 Divorced Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. BETHLEHEM STEEL Elementary/Secondary (0-12) College (1-4 or 5+) NSPECTOR Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental to is marked o မှ BENJAMIN HOWARD LILLIAN DUNSTON 19a. Informant's Name/Relationship (Type, Print 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BRIAN C. it of Health: ROGERS ARGONNE DRIVE. BALTO, MD. 21218 permit. Page 1 and 2 or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🖾 Burial 2 🗌 Cremation 3 🗗 Removal from State Department of Important: If any injury or 4-7-12 LITTLETON, NC OLIVE GROVE CHURCH CEMETERY 4 Donation 5 Other (Specify) 22. Name and Address of Facility VANGHN GREENE FUNERAL SWS M 21. Signature of Functor Licensee YORK ROAD. BANTIMORE, MD. 2/2/2 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) Day Year 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performed? Yes 2 No 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 No Hospital Other: Certificate: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined Medical 29a. Certifier 🖟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nuyte Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature at ense numbe

Registrar DHMH 17 Rev 06-2011 30. Name and add

Keu: 31. Date filed (Month, Day

R

o completed cause of deathalter

32. Registrar Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 30^a 2012 Enrique Herrera March 3:35 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Center Towson If Under 1 Year If Under 24 Hrs.
Months Davs Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months 515-40-5603 Director 1 X M 2 🗆 F 91 Jan. 15, 1921 **PERU** Usual Residence of Dece 28a-f show 10a. State at 10c. City, Town or Location 10d. Inside City Limits the Maryland Director notified 1 Yes 2 No Essex Maryland Baltimore 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 'n pe Completed by Funeral with 23a must 520 21221 United States North Marlyn Avenue ral", or items 2 Examiner mus permit, Page 1 and 2 should be filed within 72 hours after death \text{Department of Health and Mental Hygiene.} Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner muone. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 11. Marital Status Armed Force 1 Never Married 2 X Married 1 ☐ Yes 2 🂢 No If Yes, Give Spanish Baltimore, Maryland 21215-0036 1 ¥ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 Divorced Peruvian Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Doctor of Medicine Personal Practice Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) မ Isaiah Herrera Cristina Lazaro de Ortecho 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dolores Herrera / Wife 520 N. Marlyn Avenue, Essex, Maryland 21221 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory Inc | 03/30/2012 | Baltimore, Maryland 4 Donation 5 Other (Specify) Signature of Eugeral Service Licensee ALYSON 22. Name and Address of Facility Cremation Society of Maryland Inc Taylor 299 Frederick Road, Baltimo 299 Frederick Road, Baltimore, Maryland 21228 Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician Alzheimer dementia disease or condition resulting in death) yeurs Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause Fried Underlying Examiner Due to (or as a consequence of) Cause (Disease or injury ng physician and as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Medical Certificate: To Be Completed by Physician/Medical IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Dav Year Pregnant at time of death 1 Yes 2 L 9 Unknown 9 Unknown

Hospital or Attending Physician: The law requires that the death certificate be-24 hours after death. Funeral Director: After this certificate has been signed by the attending physicis Division of Vital Records, P.O. Box 68760 page 2 should be filled in by within 24 hours a To the Funeral D

Part II. Other significant conditions of	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
		24a. Was an autopsy performed? 1 Yes 2 No
25. Was case referred to medical	26. Place of Death (Check of	nly one)
examiner? 1 X Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home	e 5 Residence 6 Other (Specify) Respice
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigatio	28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at work? 1 \(\subseteq \text{Year} \) Yes 2 \(\subseteq \text{No} \) No	d. Describe how injury occurred
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	of Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier 1 Certifying Phy (Check 2 Medical Exam	sician: To the best of my knowledge, death occurred at the time, date and place, and iner: On the basis of examination and/or investigation, in my opinion, death occurred at the	due to the cause(s) and manner as stated. e time, date and place, and due to the cause(s) and manner stated

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year,

MARCH 30

TOWSON MM)

ST

2012

DHMH 17 Rev 06-2011

State Registrar

only one) 29b. Signatu

MARON

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HARLES

N

6701

12-02527	
Javell Heath	

avell Heath		State of Maryland / Department of Hea			. No. 2012	10251
Physiciar Medical Examin	1/	1. Decedent's Name (First, Middle,Last)		2. Date of Death	Day Year	3. Time of Death 1843 hrs
nedical Examin		4a. Facility Name (if not institution, give street and number) 4b. City	, Town, or Location of Death	March 29, 2	4c. County of Death	
and a		osimo riopinio i i opinio	imore If Under 24Hrs.	8 Date of Birth	(MM/DD/YYYY) 9. Birtl	nolace (State or
Funeral Director		243-37-3550 12M 2 F 19 Yrs. Mor		7-28-	Foreign	
âu â		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
Maryland 28a-f show	<u>.</u>	MD NA Baltimore		140	. Citizen of What Coun	1 X Yes 2 No
hours after death with the Maryland "natural", or items 23a or 28a-f ah Examiner must be notified at one	Director	6 -	Zip Code 21234	100	USA	uyr
with the ms 23a he noti		11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Dece	dent of Hispanic Origin? (Specify Cuban, Mexican, Puerto F		14. Race - Americ	an Indian, Black,
er death	Funeral	1 Yes 2 No	2 No specify:	110011, 010.7	Specify: Bla	ck
ours after	핡	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usu	al Occupation (Give kind of wo		16b. Kind of Business/Ir	
2 -	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) Unland	loved		NA	
MD 21215-0036 12 should be filed within 7 12 should be filed within 7 17 is marked other than unatic event, the Mediss	Se Co	17. Father's Name (First, Middle, Last) TSAIAH BENIAMIN	18.Mother's Name	(First, Middle, Ma HE4+H		
2121 tould be fi d Mental s marked tic event,		19a. Informant's Name/Relationship (Ty., rint)	ess (Street an Number or Ri	ural Route Numb	er, City or Town, State,	
ore, MD st 1 and 2 sho of Health and If item 27 is her traumati	-	TYRA WILSON-MOTHER 8 Broad 20a. Method of Disposition (No. 1)	lame of cemetery,	Date Date	MO 21231 20c. Location - City or	Town, State
Baltimore, permit. Pages 1 ar Department of Hes Important: If ite Important: Important: If ite Important: I						
Baltimore permit. Pages 1 Department of F Important: If injury or other	ł	4 Donation 5 Other Specify: 11/10 Viting 12. Signature of Funeral Service Licensee 22. Name at	nd Address of Facility May	ch F/H-	East 1101 E.N	orth Ave.
ம் ஃத்.ச. Physician	1	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mod	we. M1) 21202			Approximate Interval
/Medical		failure. List only one cause on each line. Immediate Cause (Final disease a. Gunshot Wound of Head				Between Onset and Death
xaminer		or condition resulting in death) Due to (or as a consequence of):				
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause				
ed nsit	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
be executed sician and urial - transit	dical	UNPENDED AMENDED				
760, ficate by g physic stree business the business of the bus	We.	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 2 Fetal dea	th 3 Ectopic pregnar	ncv	23d. Date of delivery Month	ay Year
Box 68760, e death certificate be the attending physical dror use as the burden	Physician/Me	past 12 months? 4 Pregnant at time of death 5 Other (S				
that the death ned by the att detached for		Part II. Other significant conditions contributing to death but not resulting in the underly	ing cause given in Part I.	23e. Did tob	pacco use contribute to	he cause of death?
ires that the signed by	d by				2 No 3 Prob	
ords, aw requir us been s	Completed			24a. Was a autops perform	y prior to c	topsy findings available ompletion of cause of
ital Recition: The laction of the la	5	25. Was case referred to medical	26,Place of Death (Check of	1 ✓ Yes 2	No 1 ✓ Ye	s 2 No
Vital ysician this cert	To Be	examiner? 1 ✓ Yes 2 No Hospital: 1 ✓ Inpatient 2 ER/Outpatient 3	DOA Other Nursing	g Home 5 F	Residence 6 Other	1
Afte		27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of Injury Mar 27, 2012 Party Mar 27, 2012 Party Natural 1800 hrs		Subject shot		
Divisi	Certification:	3 Suicide 6 Could not be determined (Specify) Local Street		or Town, St	treet and Number or Ru ate) vedere Avenue, Balti	
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in and manner stated.	the time, date and place, and my opinion, death occurred a	due to the cause it the time, date a	e(s) and manner as state and place, and due to th	ed. e cause(s)
H 3 F 8	Me		29c. License number O.C.M.E.		29d. Date signed (Mod April 2, 2012	nth, Day, Year)
3 _{8M}	-	30. Name and address of person who completed cause of death (Item 23a)				
		Do Davidada Cirabaa	e Street, Baltimore, MD	21223		
Sta Regist		1 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7				
DHMH 17 Rev 1/20	01	ORIGINAL			. Asi-	

		Plea	ise Type or	Print in I	Black In	delible In	k. Ensure	All Copie	es Are Leç	gible.	
	_	For State	State o	f Marylan	•	ertment of I tificate of I		d Mental Hy	0	0.10	LOOF
		Registrar 1. Decedent's Name (First, Middle	, Last)		Cei	incate or i	Jean	2. Date of D	Reg. No.	ULL	3. Time of Death
Physiciar Medic		Carl Elliott	Holmes					March	31, 2012	2 Year	6:15 P™
Examine	- 11	4a. Facility Name (if not institution,	give street and num	ber)		4b. City, Town, o	r Location of De	ath	4c. Count	y of Death	
<i>*</i>		Potomac Valley Nurs 5. Social Security Number				Rock	ville			ontgon	
Funeral Director		262-07-7581	6. Sex 1 X M 2 □ F	7. Age (In yrs. la 89	Yrs.	Months Days	Hours Mi		r, I, 1922	9. Birthp Count	lace (State or Foreign ry) Florida
nd how at	- 1	Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Loc	ation				10	Od. Inside City Limits
faryla 8a-f s tified	Funeral Director	Maryland Mont	gomery			Ga	ithersb	urg			1 🛣 Yes 2 □ No
the N	₫	10e. Street and Number	<u> </u>			10f. Zip Code		0	10g. Citizen of	What Count	try?
h with	nera	69 Midline Cou	rt			20)878		Unite	ed Sta	ites
r deat		11. Marital Status	Armed Fo			Vas Decedent of F Yes, specify Cuba	lispanic Origin? an, Mexican, Pu	(Specify Yes or No erto Rican, etc.)		ce - America ack, White, e	
rs after rral", o Exam	ed by	1 ☐ Never Married 2 🔀 Marri 3 ☐ Widowed 4 ☐ Divorced	15.14: 03		1948	☐ Yes 2 🕅 No	Specify:		Specify		
72 hou "natu edical	Completed		nt's Education st grade completed)		(Give k	ent's Usual Occup	during most of w	vo <i>rkin</i> g	16b. Kind of E	Business Ind	ustry
within giene.		Elementary/Seconday (0-12)	College (1-		life. DC	NOT use retired) Attorne			Privat	te Pra	ctice
	To Be	17. Father's Name (First, Middle, L						lame (First, Middle		7e)	
d Mer d Mer marke	-	Carl Christop		<u> </u>	1			Elliott			
2 shoulth an 27 is		19a. Informant's Name/Relationsh Carson Mills /		[n=Law				Rural Route Numb cville, M	-		
1 and of Hea item	ı	20a. Method of Disposition		20b. P	lace of Dispos	sition (Name of			20c. Location		
Page ment ant: If ury or		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		Dan	nestown rch Ce	Presbyter metery	lần ^A I	oril 5, 2012	Darnest	own,	Maryland
permit. Depart Import any inj		21. Signature of Onegal Service	ioenso	MO 1 C 1	Ro Ro	Name and Addre	ss of Facility Pumphre	y Funera	1_Home,	Rocky	ille, Inc. aryland 20850
	\dashv	23a. Part 1. Enter the disease, or	complications that of	M01619						Lie, M	Approximate
Physician/		shock, or heart failure. List of Immediate Cause (Final disease or condition	only one cause on ea	ch line.	0.11.0	1100	Carcin	0110	200	ciù	Interval Between Onset and Death
Medical Examiner		resulting in death)	a. Due to	as a consequ	ience of):	CPII	<u>unu</u>	Croec	7 7 (- 101	lyear
Lammer	e e	Sequentially list conditions,	b. — Due to		14000 and					_	
ecuted and I-transit	xamine	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as a consequ	ierice orj.						
execu an and rial-tra	ш	that initiated events resulting in death) Last	C. Due to (or as a consequ	ience of):						
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transt	Physician/Medical		d								
certific nding passes as	Ž	IF FEMALE: 23b. Was decedent pregnant		come of pregna					334 D	ate of delive	n.
death e atter	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No		nant at time of o		Ectopic pregnan Other (specify) _	су				Day Year
es that the des signed by the a I be detached f	Phy	9 Unknown Part II. Other significant condition			ulting in the u	nderlying cause of	ven in Part I	220 Did	tahaasa	duiberde é a de	e cause of death?
ires th signe d be c	d by					,g -u-oc g					ably 4 Unknown
v require s been si should	ompleted							24a. Wa	san 24b.		sy findings available
rsician: The law is certificate has the	Com				·			per	opsy formed? s 2 No	prior to condeath? 1 Yes	npletion of cause of
cian: ertifica ector, p	Be	25. Was case referred to medical examiner?	Maraital				lace of Death (C				
Physic this c	은	1 Yes 2 No 27. Manner of Death	Hospital:	Inpatient 2	ER/Outpatien		4 Linursing	Home 5 Res			
nding ath. :: After e funel	cate	1 Natural 5 Pendin 2 Accident Investig	ig (Mont	th, Day, Year)	injury	28c. Injur worl M 1	yai k? Yes 2 □ No	28d. Describe	how injury occur	red	
r Atte ter de irector	Certificate:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	not be 28e. Place	of Injury - At ho		et, factory, office			(Street and Numb	ber or Rural	Route Number,
To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate his completed filled in by the funeral director, page		29a. Certifier 1 Lecrtifying					alaka anal alaw				
n 24 hr e Fun	Medical	(Check 2 L Medical E	Physician: To the b xaminer: On the bas Nurse Practioner:	is of examination	n and/or invest	igation, in my opini	on, death occurre	ed at the time, date	and place, and du	ue to the cau	se(s) and manner stated
To the vithii comp		29b. Signature and title of certifier	\bigcap	^-		29c. Licens	e number		29d. Date signe		
1/an		Money	alle	209		D3	5826	2	Apri	1 2,	2012
13, 0.		30. Name and address of person of A MENDH I	who completed caus	e of death (Item		rint) 143 Si	hade	Grove	Ct B	aith	ersburg
State		31. Date filed (Month, Day, Year) APR 0 3 20	112 A 32. R	egistrar's Signat			- 04	1.0-	· rvi	(D 2	05//
Registra	r	MI 11 0 3 20	IL KEN	a p.	gar						

Registrar DHMH 17 Rev 7/2009

Physician/ Patricia 31 Whitaker Hawfield 2012 March Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery Social Security Number If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year Months Days 579-40-9443 Director 1 🗆 M 2 🔀 F 81 September 26,1930 Virginia Usual Residence of Decedent show 10b County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location Director Maryland Montgomery Bethesda 10e. Street and Number 10g. Citizen of What Country? Funeral 6117 Swansea Street 20817 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian þ 1 Never Married 2 Married Yes Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify "natural", 3 Widowed 4 Divorced Completed White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4 Administrator Church Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clyde R. Whitaker Elsie L. Smoot . Page 1 and 2 should tment of Health and N tant: If item 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James H. Hawfield / Husband 6117 Swansea Street, Bethesda, Maryland 20817 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State April 2, 2012 permit. Page 1 a
Department of H
Important: If ite
any injury or ot
once. cemetery, crematory or other place 1 🗆 Burial 2 ٌ Cremation 3 🗀 Removal from State Montgomery Crematorium, Inc. 4 Donation 5 Other (Specify) Bethesda, Maryland Signature of Funeral Service Licenses Name and Address of Facility Funeral Home / Bethesda-Chevy Chase, Inc. lette Brigist M01305 /557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 Part 1. Epper the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Immediate Cause (Final Ph_sician/ Ovarian Cancer disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Septicemia Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or injury attending physician and I for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Box 68760 1205 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 \(\sum \) Yes 2 \(\textbf{X} \) No Month Pregnant at time of death 5 Other (specify) 1 ☐ Yes ∠ ☑ 9 ☐ Unknown signed by the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? End Stage Renal Disease 1 Tes 2 X No 3 Probably 4 Unknown Records, 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate 1 ☐ Yes 2 ☐ No Hallield, patric of Vital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No ပ္ 1 X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2. Date of Death

3. Time of Death

12:05 PM

1 Yes 2 X No

Approximate Interval Between Onset and Death Years

Dav

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

April 1, 2012

Year

m

Division

31. Date filed (Month, Day, Year) Registrar

2 Accident
3 Suicide
4 Homicide

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Nelson Kalil, MD

5 Pending

Investigation

Could not be

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

determined

For State Registrar

1. Decedent's Name (First, Middle, Last)

5454 Wisconsin Avenue, #1300, Chevy Chase, Maryland 20815 32. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

DHMH 17 Rev 06-2011

work

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 Tes

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29c. License number

D51616

2 🗌 No

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend 8, per fh, g927 5-4-12 sm
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** ntina LIDGINS 2012 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Raven Center BALTO. PARKVILLE If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month Day Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 🗹 F 217-16-146 Director MARYLAND Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10h County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at MD HARFORD FOREST HILL Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1548 MORSE ROAD 21050 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify þ Specify: WHITE 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOME 12TH HOMEMAKER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MARY ROSE RECUPERO ANTHONY TROVATO 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SON MORSE ROAD FOREST HILL, MD. 21050 CHARLES HUDGINS 1548 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Bunal 2 Cremation 3 Removal from State -3-2012 4 ☐ Donation 5 ☐ Other (Specify) PARKWOOD CEMETERY PARKVILLE, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME, INC. BALTO.MD. 6415 BELAIR ROAD 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) ongestive /Medical Due to (or as a consequence of): ^{*}Examiner 101 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-transit Division or Vital Records, P.O. Box 6876000 Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy ate has been signed by the atte page 2 should be detached for Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 2ment 10 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes No 24a. Was an autopsy performed? 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 24 hours after death. 5 Pending investigation 1. Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital of within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

10d. Inside City Limits

Approximate Interval Between Onset and Death

Day

29d. Date signed (Month, Day, Year)

03-28-2012

Year

1 ☐ Yes 2 X No

State Registrar

31. Date filed (Month, Day, Year) APR 0 3 2012

29b. Signature and title of certifier

EST HER

CRNP 62. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

29c. License number

P123693

Emge Rd Battimore, Md

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. I. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Herbert Louis L 7:10A.M. Narel Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town. or Location of Death 4c. County of Death **Examiner** Baltimore Washington Medical Center Glen Burnie Anne Arundel Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours April Day Ye ^{ar)}1933 215-30-4594 78 Maryland **Director** 1 **X** M 2 □ F Usual Residence of Dece or 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Pasadena 1 Yes 2X No 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o 510 Sylvan Way 21122 Funeral USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Ke Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: white Specify: Completed 3 Widowed 4 Divorced Korean Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working r than " c, the M life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Maryland 21 Welding forman Coast Guard and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Frank Herbert Alice Dobrajski traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t: If item 27 is or other tra Pauline Herbert 510 Sylvan Way Pasadena MD 21122 spouse Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ţ, Department of Important: If it any injury or o once. cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State Crestlawn Cemetery 4/2/2012 West Friendship MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Signature Stallings Funeral Home PA. <u>3111 Mountain Road Pasadena MD 21122</u> 23a. Part 1. Enter the disease, or complishock, or heart failure. List only one ation that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Exami executed the burial-trai Due to (or as a consequence of): resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year signed by the at the detached for Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 3 N Probably 4 ☐ Unknown 1 Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was ar page 2 autopsy perform 1 ☐ Yes 2 ☐ No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 Yes မှ 1 Department 2 ER/Outpatient 3 DOA funeral 27. Manner of Deat 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A the f 2 Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 hou

To the Fune

completely fi (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 30. Name and addr on who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Steven Joseph Ireland 2012 0657 March Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Upper Chesapeake Hospital Bel Air Harford 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours (Month, Day, Year, Director 213-54-1254 1**火** M 2 □ F 63 Aug 17, 1948 Maryland Usual Residence of Deceden f show or 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Yes 2 No Harford Edgewood 10e. Street and Number 10f. Zip Code 9 10g. Citizen of What Country? Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a on important: if item 27 is marked other than "natural", or items 23a on any injury or other traumatic event, the Medical Examiner must be once. Funeral 1903 Larch Court 21040 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 X Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Yes, Give Specify: White Completed 3 Widowed 4 Divorced Year or Dates. 1972-76 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Social Security Admn. Federal Government Claims Representative Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Page 1 and 2 should be ment of Health and Ment Carl Ireland Mettie Lewis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dawn Marie Ireland/wife 1903 Larch Court Edgewood, MD 21040 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place, Final Journey Crematory 04/02/12 Woodbine, MD 21. Signature of Funeral Service Lice Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Drobable disease or condition resulting in death) Medical Due to (r as a consequence of) **Examiner** Sequentially list conditions, Due to (or se a noneccuence on): cause. Enter Underlying Cause (Disease or injury burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 signed by the attending priysi IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 1 Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate has 1 Yes 2 No Hospital or At ending Physician: 24 hours after ceath. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) completely filled in by the funeral dir. 1 \square Yes ဂ္ 1 Inpatient 2 R/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 1 Natural 5 Pending Accident
Suicide Investigation 24 hours after reatle Funeral Direc or. 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signat License number 29d. Date signed (Month, Day, Year) 0057 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15×1 Bd Air MD YORY apper Chesopoulle Dr. 210 500 31. Date filed (Month, Day, Year) Registrar's Signature State APR 0 Registrar EW HMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2012 4:408 ackson Medical 4b, City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) County of Death Examiner Vursing Flying 7: Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Director show 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland Funeral Director Examiner must be notified 1 Yes 2 ☐ No 28a-1 no Timore 0. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 21213 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc þ 2 No "natural", or 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 ☐ No Specify. 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than, Elementary/Secondary (0-12) College (1-4 or 5+) other traumatic event, the Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, It once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Balto MD 21213 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State atonsville, mb Crematory 4 Donation 5 Other (Specify) 21229 21. Signature Funeral Service Lice see 22. Name and Address of Facility suto.mo 23a. Part 1 of first rive disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death VIIV Physician/ ull disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day 4 Pregnant at time of death g Unknown 1 Yes 2 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 15halky 1 ☐ Yes 2 R No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an performed? 2 🗌 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 📈 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: Ai
completely filled in by the fi 1 Yes 2 🗌 No Investigation Could not be Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 📈 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 □ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of ertifie 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3455 WILKENS ANE, BALTIMORE MD 21229

DHMH 17 Rev 06-2011

State Registrar 32. Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day 2012 Year William Jackson R. March 13:40 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F Months Month E March Hours Director Yrs 578-58-7293 16 5 194 Wash Usual Residence of Decedent shov 10a. State 10b. County within 72 hours after death with the Maryland er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No DC Washington, 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3674 Highwood Drive S.E. 20020 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces
1 Yes 2 If Yes, Give
Year or Dates Black, White, etc. 1 Never Married 2 X Married þ 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hyglene. Important: If item 27 is marked other than 's mirror or other traumatic event, the Me any injury or other traumatic event, the Me genee. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Clerk DC Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Edward Jackson Anna Ross 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Joyce Jackson/Wife</u> 3674 Highland Dr, SE, Wash., DC 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Washington Nat Cem 3/16/12 Suitland, MD neral 6 22. Name and Address of Facility Austin Royster Funeral Home (olien 14th Street, NW, Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day ☐ Pregnant at time of death☐ Unknown signed by the sid be detached f 9 🕅 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 ☐ Yes 2 📈 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perforn certificate 1 Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 X No မ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify within 24 hours after death.

To the Funeral Director: After this funeral 27. Manger of Death 28a. Date of injury (Month, Day, Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending work? 1 🗌 Yes 2 No Investigation
6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Manth, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

APR 0

3

dress of person who completed cause of death (Item 23a) (Type, Print)

			For	State of Mar				nd Mental Hy	giene	0000
			State Registrar	4)	Cer	tificate of L	Death		Reg. No.	2 10262
	Physicia: Medic		1. Decedent's Name (First, Middle, L James R. K					2. Date of De March	38 20°4"	3. Time of Death 2 3:03p M
	Examin		4a. Facility Name (if not institution, gi Stella MAri			4b. City, Town, or TO	r Location of D	Death	4c. County of Dea	
	Funeral Director		5. Social Security Number 199–14–6851		n yrs. last birthday) 87 Yrs.	If Under 1 Year Months Days			th y, Year) 29,1924	irthplace (State or Foreign ountry) PA
	laryland 3a-f show ified at	Director	Usual Residence of Decedent 10a. State 10b. County MD Balt	imore 1	Oc. City, Town or Loc Midd	eation Le Rive	r			10d. Inside City Limits 1 ☐ Yes ※☐ No
	with the N s 23a or 28 nust be not	Funeral Dir	10e. Street and Number 206 Middlewa	y Road		10f. Zip Code 212	20		10g. Citizen of What C	Country?
m. 036	be filed within 72 hours after death with the Maryland ental Hygiene. ked other than "natural", or items 23a or 28a-f show ked other than "natural", or items 23a or 28a-f show ic event, the Medical Examiner must be notified at	by	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 🏿 Widowed 4 ☐ Divorced	12. Was Decedent Eve Armed Forces? 1♣ Yes 2 ☐ No If Yes, Give Year or Dates.	lf If	Vas Decedent of H Yes, specify Cuba	an, Mexican, P	? (Specify Yes or No- uerto Rican, etc.)	14. Race - Am Black, Wh Specify: W	ite, etc.
MARCH 30, 2012 3:03 p.m. Baltimore, Maryland 21215-0036	nin 72 hours ne. than "natur e Medical I	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education	(Give F	ent's Usual Occup ind of work done of NOT use retired) eel Wor	during most of	f working	16b. Kind of Busines Beth S	
2 3:03 and 2121	1 and 2 should be filed within 72 if Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the Me	To Be C	12th 17. Father's Name (First, Middle, Las unknown	*)			18. Mother's	s Name (First, Middle,		
, 2012 Maryla	d 2 should alth and Me 27 is mar		19a. Informant's Name/Relationship Mary Sue Flor					or Rural Route Numbe Meadows	er, City or Town, State, 2 Bear Del	Zip Code) aware 19701
30. imore,	permit. Page 1 and Department of Heal Important: If item 3 any injury or other once.		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spe		20b. Place of Dispo cemetery, cren Bayviev	sition (Name of natory or other place V Crema	tory (Date 4/2/12	20c. Location - City of Baltimo	1
MARCH Baltim	permit. Departr Import. any inji		21. Signary of Funeral Service Lice	Kun	1		lly Fu	neral Ho	e Ave. Ba	
0	Physician Medical Examiner	ő P	23a. Part 1. Enter the disease, or co shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	cone cause on each line. CEREBRO	VASCULAR consequence of):		ng, such as ca	rdiac or respiratory ar	rrest,	Approximate Interval Between Onset and Death
	ate be executed hysician and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	consequence of):					
09289	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	n/Medical	IF FEMALE: 23b, Was decedent pregnant	d	pregnancy □ Fetal death 3 □				23d. Date of c	delivery
O. Box 687	the death by the atte tached for	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No g ☐ Unknown	4 ☐ Pregnant at t 9 ☐ Unknown	ime of death 5	Other (specify)			Month	Day Year
	requires that the des been signed by the s should be detached	by	Part II. Other significant conditions	contributing to death but	not resulting in the u	nderlying cause gi	iven in Part I.	1 🗆	tobacco use contribute Yes 2 No 3	Probably 4 Unknown
ES KE Recoi	nysician: The law re nis certificate has be I director, page 2 sh	Completed						•	opsy prior to death:	autopsy findings available o completion of cause of ? es 2 No
JAMES /ital Re	sician certifi irecto	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🗶 No	Hospital:		Oth		(Check only one)	idence 6 X Other (Sp	ecify) HOSPICE
of V	g Physer this	te: To	27. Manner of Death	28a. Date of injury (Month, Day,	t 2 ER/Outpatier 28b. Time of Year)		ry at		how injury occurred	ecny) HODI TOD
JAMES KELLER Division of Vital Records, P.	or Attendin fter death. irector: Aft n by the fur	Certificate:	1 X Natural 5 ☐ Pending 2 ☐ Accident Investiga 3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ion t be	· - At home, farm, str	M 1 _	Yes 2 N		Street and Number or F wn, State)	Rural Route Number,
وَ	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	Medical C	(Check 2 Medical Exa	hysician: To the best of m miner: On the basis of exa urse Practitioner: To the b	mination and/or inves	tigation, in my opini	ion, death occu	urred at the time, date	and place, and due to th	e cause(s) and manner stated.
	To the virbin	2	29b. Signature and title of certifier	~ bno	NP	29c. Licens		12	29d. Date signed (Mon	
	2 81.		30. Name and address of person where TRACIE L. MORG.	AN, CRNP 23	00 DULANE		RD. J	TIMONIUM,	MD 21093	
	Sta Registr		31. Date filed (Month, Day, Year) APR 0 3 2012	32. Registrar	s Signature					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #20 bic. Per FH G926 24/06/2012 IH State of Maryland Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 04 Andrietta Vernette King 2012 8:53 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice **Baltimore** 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days 218-44-2598 M771471945 Maryland **Director** 66 1 🗆 M 2 🗆 F or items 23a or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he motified at 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits MD 1
✓ Yes 2
☐ No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 2020 Featherbed Lane 21207 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Force Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. Completed 3 Widowed 4 Divorced Specify: Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Clerical Dept Of Social Services Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Charles Vernon King Bessie Harris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Danita Johnson / Daughter 623 Wadsworth Way, Baltimore, MD 21239 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cem**Arburus Cemetery** King Memorial Park Baltimore MD Windsor Mill. 4/9/2012 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility Vaughn Greene Funeral Svcs 4905 York Road Baltimore, MD21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due (or as a consequence of): **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury burial-tra that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy in the past 12 months? for 5 Other (specify) Month Pregnant at time of death Day 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a, Was an Were autopsy findings available prior to completion of cause of page 2 autopsy performe death? 2 🗌 No 1 🗌 Yes director, To Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending injury within 24 hours after death.

To the Funeral Director: A completely filled in by the fi Accident Investigation 6 Could not be Suicide in by Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARI

State Registrar 31. Date filed (Month, Day, Yea

32. Registrar's Signature

707 N-C

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ LILLIAN MARCH 29,2012 KAHL 11:10P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death 4910 FORGE ROAD PERRY HALL BALTO. Social Security Number 7. Age (In yrs. last birthday) Year If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral Director** 1 🗆 M 2 🗶 F 212-18-2616 92 MARYLAND 1-7-1920 Usual Residence of Deceden 28a-f show be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD. BALTO. PERRY HALL 1 Tes 2 No 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a Examiner must 4910 FORGE ROAD 21128 USA or items 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces by Black, White, etc 1 Never Married 2 Married Yes 2 XNo Maryland 21215-0036 1 Yes 2 No Specify. WHITE Yes, Give "natural" 3 X Widowed 4 Divorced Completed Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) HT8 HOMEMAKER HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 9 CONRAD GUNZELMAN THERESIA HOLTHAUS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .8 and 2 s Health THERESIA WITTHAUER DTR. 4910 FORGE ROAD PERRY HALL, MD. injury or other Baltimore, tem 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of H
Important: If ite
any injury or otl Date 20c. Location - City or Town, State ■ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) BEL AIR MEMORIAL 4-2-2012 BEL AIR, MD. 22. Name and Address of Facility SCHIMUNEK FUNERAL HOME, 21. Signature of Funeral Service Licenses Þ 9705 BELAIR ROAD NOTTINGHAM, MD. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate nterval Retween nset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical CERTIFICATION APPROVED TO MEDICAL ELABORIES **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or) s a consequend of) Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 the as 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery ō in the past 12 months?

1 Yes 2 No Month Dav 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Atherasclerotic Vascular 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Clostolium autopsy performe 1 ☐ Yes 2 No 1 ☐ Yes 2 🗷 No Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2 🗷 No Division of Vital Be 26. Place of Death (Check only one) Hospital: 2 No မှ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending injury 1 Yes 2 No Tripped on foot while turning the Funeral Director: Pumpletely filled in by the Investigation 23/12 10 = 60 a.M 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 4910 Forge Kitchen Home hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 2 29d. Date signed (Month, Day, Year) 045568 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

Registrar

32. Registrar's Signature

3

a

			For State of Mary		artment of F		,	2011	2 10265
			Registrar 1. Decedent's Name (First, Middle, Last)		tinicale of L	Jeaur	2. Date of Dea	Reg. No. C U I (3. Time of Death
	Physicia Medic		Robert Bruce Klemm				Month Man	rch 30, Year	12 5:20 PM _M
	Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or	r Location of Death		4c. County of Dea	ath
			Gilchrist Center for Hospice 5 Social Security Number 6 Sex 7 Age //n v		If Under 1 Year	Towson	Ta a	Baltime	
	Funeral Director			yrs, last birthday) 69 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day Jul 3		irthplace (State or Foreign ountry) ∋w York
	s filed within 72 hours after death with the Maryland tal Hygiene. 3d other than "natural", or items 23a or 28a-f show event, the Medic∗l Examiner must be notified at	tor	10a. State 10b. County 10c	c. City, Town or Lo	cation				10d. Inside City Limits
	within 72 hours after death with the Maryland glene. er than "natural", or items 23a or 28a-f sho the Medic I Examiner must be notified at	Director	NY Suffolk	Rocky P					1 🗆 Yes 2 🗶 No
	ith the		10e. Street and Number		10f. Zip Code			10g, Citizen of What C	,
	ems arr	Funeral	20 Soundway Drive 11. Marital Status 12. Was Decedent Ever in	n U.S. 13. 1	11778 Was Decedent of Hi		ecify Yes or No-	United S	
ဖွ	or it	by F	1 ☐ Never Married 2 ☐ Married Armed Forces? 1 ☐ Yes 2 ⚠ No		If Yes, specify Cuba	n, Mexican, Puerto		Black, Whi	
003	urs af tural" i Exa	ted	3 Widowed 4 Divorced If Yes, Give Year or Dates.		1 Yes 2 No	Specify:		Specify:	White
15-(72 ho	ple	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occup kind of work done o		ing	16b. Kind of Business	
21215-0036	ithin ene. r thar the M	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 5+	1	ONOT use retired) mist			Chemical Lab	Scientific
Q	be filed w ental Hygi ked othe ic event, i	Be	17. Father's Name (First, Middle, Last)	Cire	misc	18. Mother's Nam	e (First, Middle, i		
ylar	ould be find marked matic events	2	Clarence Oliver Klemm			Blanch	e Abigai	l Borgese	
Maryland	permit. Page 1 and 2 should be file Department of Heath and Mental Important: If item 27 is marked c any injury or other traumatic evence.		19a. Informant's Name/Relationship (Type, Print) Laura Klemm / Daughter	I				; City or Town, State, Z WI 53081	ip Code)
Baltimore,	of He		20a. Method of Disposition 1 □ Burial 2 ★ Cremation 3 □ Removal from State	Ob. Place of Dispo	sition (Name of natory or other plac	rel	Date Mar 31	20c. Location - City o	r Town, State
Ē	t. Pag tment tant: jury c			**	ake Crema	1	2012	Beltsvill	e, Maryland
Ba	permil Depar Impor any in		helacca bochemo	γ	Name and Address Cremation 8717 Gree	n Pasture	s Drive '	Towson Mary	land 21286
			23a. Part 1. Enter the disease, or complications that caused the c shock, or heart failure. List only one cause on each line.		er the mode of dying	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between
Y	nysician/ Medical	9.3	Immediate Cause (Final disease or condition resulting in death)	nexealie	Caucer				Onset and Death
	Examiner		Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions	sequence of):	00,000 (Jan Sail	,		
		ner	if any, leading to immediate Due to (or as a cons		nauga c				
R	ate be executed onysician and the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.						
ม่า	e exec	al E	resulting in death) Last Due to (or as a cons	sequence of):					
200	ate by physic the b	edical	d						
687	eath certificate be executed attending physician and d for use as the burial-transi		IF FEMALE: 23c. If yes, outcome of pre	egnancy					
XOX	eath c atten	iciar	in the past 12 months? 1 Live Birth 2 1 Pregnant at time	Fetal death 3 [Ectopic pregnanc Other (specify)	у		23d. Date of de Month	Day Year
В	the di by the racher	hys	9 Unknown						
<u>~</u>	s that gned be de	þ	Part II. Other significant conditions contributing to death but not	t resulting in the u	nderlying cause giv	en in Part I.		bacco use contribute to	
rds	equire een si nould	ted	Citthosis:				1 🗆 Y	es 2 No 3 □ F	Probably 4 Unknown
000	law re has b	Completed					24a. Was a autop:	sy prior to	topsy findings available completion of cause of
<u> </u>	sician; The law r certificate has b lirector, page 2 s		OS Was assessed and the second and t			 -	perfor 1 ☐ Yes		s 2 No
/ita	nysiciar lis certii I directo	œ	25. Was case referred to medical examiner? 1 Yes 2 No No Hospital:		Otho	ace of Death (Checi	, , , , ,		lada ladi
of	g Phy er this neral c	ie: To	27. Manner of Death 28a. Date of injury	2 ER/Outpatien 28b. Time of	28c. Injury	at		ence 6 Other (Spec	city) Layon, hospite
on	endin sath. or; Aft he fur	ficat	1 ☑ Natural 5 ☐ Pending (Month, Day, Year 2 ☐ Accident Investigation	r) injury	M 1 □	? Yes 2□No			
Division of Vital Records, P.O. Box	or Atter de lirector in by t	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - A building, etc. (Spe	At home, farm, stre	eet, factory, office		28f. Location (St City or Town	reet and Number or Ru	ıral Route Number,
	pital o		29a. Certifier 1 Certifying Physician: To the best of my kn			- 3			
	To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. Within 24 hours after death. Within 24 hours after death. Completely filled in by the funeral director, page 2 should be detached for the funeral process.	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my kn 2 Medical Examiner: On the basis of examination only one) 3 Certifying Nurse Practitioner: To the best	ation and/or invest	igation, in my opinio	 n. death occurred at 	the time date an	d place, and due to the	cause(s) and manner stated
	Vithir Comp		29b. Signature and title of certifier		29c. License	number		20d Date signed (Mont	h Day Yearl
			> Lyed Olihas MD		D721	39	U	March 3016	2012
	15		30. Name and address of person who completed cause of death (I	Item 23a) (Type, P	rint)	Balli	more M	Marel 30 16 2120 6	1 .
	Stat Registra		31. Date filed (Monty, Day Year) APR 0 3 2012 32. Registrarie Sig	gnature					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ April 2012 8:52 A Arline Marie Langer Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Baltimore <u>Greater Baltimore Medical Center</u> Towson Birthplace (State or Foreign Country) ear If Under 24 Hrs. 8. Date of Birth **Funeral** Age (In vrs. last birthday) Months Hours **Director** 383-36-4854 1 □ M 2 🕱 F MI 77 Nov. 2, 1934 Usual Residence of Deced 10a. State ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 💢 No MD Baltimore Cockeysville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10606 Lakespring Way 21030 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. by 1 Never Married 2 X Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Store Manager Variety Store Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Roscoe Cutsinger Charlotta Briggs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark J. Langer/Son 1223 Madison St. Alexandria, VA 22314 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Atlantic Crematory 2012 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Local 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, 10 W. Padonia Road Timonium, MD 21093 Mickael Inc. J. Flagle 23a. Pirt 1. Enter lie disease or com shi eart failure. List only c or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, tonly one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ neummu disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner attending physician and for use as the burial-transii resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☑ No 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ atrial Abullation 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed Yes 2 after death.

Director: After this certificate! 2 No 1 🗌 Yes 25. Was case referred to medica Certificate: To Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☐ No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No filled in by the ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide City or Town, State) within 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 L. Certifying Nurse Practitioner: To the best of my kno-29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Cynthia man we 00007347 4/1/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 N Charles St Bultimor MO 21204 ynthia Soriano MD 31. Date filed (Month, Day, Year) 82: Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month March 30, 1:45 PM Frank Edward Leahy 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 206 1 Southerly Ct. Apt. Baltimore Towson 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 85 Months Days (Month Day Year) 1926 253-44-2758 New Jersey Director 1 🗙 M 2 🗆 F Usual Residence of Decede 28a-f show at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director must be notified Baltimore 1 Yes 2 No Towson ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 1 Southerly 21286 United States Ct. Apt. 206 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, rmed Forces?
Yes 2 [
Yes, Give Black, White, etc. or, þ 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 filed within 72 hours after 1 ☐ Yes 2 XNo Specify: "natural", Completed Specify. 3 Widowed 4 Divorced White Year or Dates. WWII 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1 $_{\bar{\boldsymbol{A}}}^4$ or 5+) Civil Engineer Gen Star Be 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) ည Page 1 and 2 should be or ment of Health and Menta James William Leahy Elizabeth M. Kelly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. Joyce Leahy /Wife 1 Southerly Ct. Apt. 206 Towson, MD 21286 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Mar 31 1 Burial 2 Cremation 3 Removal from State Beltsville, Maryland 2012 4 Donation 5 Other (Specify) Chesapeake Crematory 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Cremation and Funeral Alternatives Hebecco Remon 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each lin Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) 0 noma Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any fracting to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to or as a consequence of resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) for 1 in the past 12 months? Pregnant at time of death Month Year Day signed by the a 1 Yes 2 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 1 Yes 2 No Yes 2 N 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other ျ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending work? 2 No M Accident Investigation the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number

P.O. Box 68760 Records, Hospital or Attending Physician: Division of Vital after death. Director: Aft in by within 24 hours aft To the Funeral Dir completely filled in State

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

building, etc. (Specify)

STROMBERO

32. Registrar's Signature

DHMH 17 Rev 06-2011

Registrar

Medical

29a. Certifier

(Check only one) 29b. Signature and title

31. Date filed (Month, Day, Year)

1734

1 🔏 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be executed

		Please Type or Print in Blac	ck Indelible Ink. Ensure A	II Copies Are Legible.						
	-	_ FOI	Department of Health and M Certificate of Death	lental Hygiene Reg. No. 2012 10268						
Physiciar Medic		1. Decedent's Name (First, Middle, Last) Rita Lavin		2. Date of Death Month Day Year March 29, 2012 1, 45 PM						
Examine		4a. Facility Name (if not institution, give street and number) Charlottes Home 5. Social Security Number 6. Sex 7. Age (in yrs. last birt)	4b. City, Town, or Location of Death BoonSboro If Under 1 Year I If Under 24 Hrs. I	4c. County of Death Washington 8. Date of Birth 9. Birthplace (State or Foreign						
Funeral Director		. □ M o Nf =	Yrs. Months Days Hours Min.	(Month, Day, Year) Jul 08, 1921 Maryland						
28a-f show	Director	10a. State 10b. County 10c. City, Town	n or Location ferson	10d. Inside City Limits 1 ☐ Yes 2 No						
s 23a or 2 ust be no	Funeral Di	10e. Street and Number 2181 Bellmonte Court	10f. Zíp Code 21755	10g. Citizen of What Country? United States						
	술	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I	cify Yes or No- Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: White						
than "natur Than "natur The Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+)	Decedent's Usual Occupation (Give kind of work done during most of working) life. DO NOT use retired)	16b. Kind of Business Industry Own Home						
Vental Hygie arked other itic event, th	To Be (17. Father's Name (First, Middle, Last) Edward F. Chabot	Home Maker 18. Mother's Name Christ	(First, Middle, Maiden Surname)						
alth and N 27 is ma r trauma		19a. Informant's Name/Relationship (Type, Print) Joseph Lavin /Son		Route Number, City or Town, State, Zip Code) t Jefferson, MD 21755						
nent of Hee ant: If item ury or othe		1 ☐ Burial 2 X Cremation 3 ☐ Removal from State cemeter	f Disposition (Name of ry, crematory or other place) sapeake Crematory	Mar 31, 20c. Location - City or Town, State, Beltsville, Maryland						
Departi Importi any inji once.		21. Signature of Funeral Service Licensee MOISS 22. Narce and Address of Facility Funeral Alternatives 8717 Green Pastures Drive Towson Man								
ysician/ Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of the condition of the co	not enter the mode of dying, such as cardiac o							
taminer	xaminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	οή:							
ysician and ne burial-tra	ш	that initiated events resulting in death) Last C. Due to (or as a consequence of d.	of):							
within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	h 3 Ectopic pregnancy 5 Other (specify)	23d. Date of delivery Month Day Year						
en signed by vuld be detac	þ	Part II. Other significant conditions contributing to death but not resulting i	in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably						
cate has be page 2 sho	Completed			24a. Was an autopsy performed? 1 Yes 2 No 2 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No						
s certifi director	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: Hospital: I Inpatient 2 ER/OL	26. Place of Death (Check utpatient 3 DOA Other: 4 Nursing Ho	only one) me 5 Residence 6 □ Other (Specify)						
eath. vr: After thi	Certificate: 1	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of injury (Month, Day, Year)		28d. Describe how injury occurred						
rs after de al Directo led in by th		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, fa building, etc. (Specify)	arm, street, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)						
nn 24 hou the Funer	Medical	only one) 3 Certifying Nurse Practioner: To the best of my know	or investigation, in my opinion, death occurred at yledge, death occurred at the time, date and place	the time, date and place, and due to the cause(s) and manner stated. e, and due to the cause(s) and manner as stated.						
Mitta Con		29b. Signature and title of certifier Nane mana Can ex	29c. License number R093556	29d. Date signed (Month, Day, Year) 3/29/12						
り		30. Name and address of person who completed cause of death (Item 23a) (Nancy Manahan 1/26 Opti	(Type, Print) Court Hagerstown	Md 21740						

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 7,2012 1746PM MARCH Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) If Under 24 Hrs. Funeral 9. Birthplace (State or Foreign Hours 1 M 2 D F **Director** 3-27-39 *laryland* or 28a-f show 10h Count 10c. City, Town or Location 10d. Inside City Limits אראלין ארבי ארבי ארמין (Baltimore, ארמין ארמין Baltimore, Maryland 21215-0036 Examiner must be notified at Director 1 Yes 2 No 10g. Citizen of What Country? 23a Funeral 110 202 NB J.S.A. "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces' Black, White, etc. _ Q 1 Never Married 2 Married Yes 2 No Yes, Give 1 ☐ Yes 2 ☑ No Specify Completed 3 🗌 Widowed 4 🗌 Divorced Year or Dates WHITE traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) CONTRACTOR Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Sumame) 7 is marked ည EISNER SR. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health tem 27 710 202ND ST. PASADER VIRRINIA LEISNER MD.21122 item od of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If it any injury or o of cemetery, crematory or other place 1 Durial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Sign 2601 MOUNTAIN DO HISADENA 23a. Part 1. Enter the disease. is that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. Lit Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) CARDIAC ATAZ Annyma Medical Due to (or as a consequence of) **Examiner** C-7018 PLO1918M Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Directo for as a nunsequence off Exami physician and the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) attending physiciar Physician/Medical The law requires that the death certificate be Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) fo in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year 9 Unknown P.O. ģ been signed k should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? Yes 2 No certificate 2 No 1 Tes To the Hospital or Attending Physician: Division of Vital funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 No ျပ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) s after death.

Director: After this 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 1 🗌 Yes 2 No 2 Accident the Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined within 24 hours a

To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 pertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number Marien m 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MIDICAN Asmite no 31. Date filed (Month, Day, Year) State Registrar

		-	For	State of Man	,			Mental Hy	giene	110	10070
			State Registrar	(4)	Cert	tificate of D	eath		Reg. No.	116,	11210
	Physicia	n/	Decedent's Name (First, Middle, in the control of the control	,	Lagg	20.036		2. Date of De Month		Year	3. Time of Death 7:40 P _M
~**	Medic	al .	Helen 4a. Facility Name (if not institution, c	Sophie	Less		Leastion of Dooth	Marc	4c. County		7 7 7 0 2 10
	Examin	er	7844 Tick Nec			4b. City, Town, or Pasa				ie Aru:	nde1
	Funeral				n yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	h	g. Birthpla	ace (State or Foreign
	Director		216-32-9662	1 □ M 2 X XF	96 Yrs.	Months Days	Hours Min.	(Month, Da		Country	MD
	r ow		Usual Residence of Decedent 10a, State 10b, County	1	Oc. City, Town or Loc	otion		12/15	1913	110	Id. Inside City Limits
	rylan I-fsh ieda	cto			Pasade						1 Yes 2XXNo
	r 28a notif	Director	MD Anne 10e. Street and Number	Arunde1	1 asauc	10f. Zip Code			10g. Citizen of	What Countr	
	vith th	ıal	7844 Tick Neck	Road			122		_	SA	·
	ould be filed within 72 hours after death with the Maryland did Mental Hygiene. marked other than "natural", or items 23a or 28a-f show marked other than "natural" are must be notified at matic event, the Medical Examiner must be notified at	Funeral	11. Marital Status	12. Was Decedent Ever		/as Decedent of His	spanic Origin? (Spe			ce - America	
ဖွ	ter de , or it	by	1 Never Married 2 Marrie	Armed Forces? 1 ☐ Yes 2 ▼ No If Yes, Give		Yes, specify Cubar ☐ Yes 2 🗓 No		nicari, etc.)	1	ck, White, et	
8	urs al tural" al Exa	ted	3XXWidowed 4 ☐ Divorced	Year or Dates.					Specify	WIIIF	
5	72 ho n "na ledic	Completed	15. Decedent (Specify only highes	t grade completed)	(Give k	ent's Usual Occupa ind of work done d ONOT use retired)		ing	16b. Kind of E	Business/Indu	ustry
12	/ithin iene. r thai	ပ္ပြ	Elementary/Secondary (0-12)	College (1-4 or 5+)		Homemake	r		0wi	n Home	:
D	be filed w ental Hyg 'ked othe ic event,		17. Father's Name (First, Middle, La	st)			18. Mother's Nam	e (First, Middle,	Maiden Surnam	ie)	
ılar	d be f Aenta arked itic ev	입	William	Shaney			Mar	garet	Zic	k	
lan	should be file h and Mental I 7 is marked o traumatic eve		19a. Informant's Name/Relationshi	p (Type, Print)		g Address (Street a					
≥ .	nd 2 ealth m 27 her tr		Mr. Robert H. Le	ssner/ Son		7 McGowan	т				
Baltimore, Maryland 21215-0036	Je 1a It of H If ite or oth		20a. Method of Disposition 1	3 ☐ Removal from State	20b. Place of Dispos cemetery, crem	atory or other place	e) .	Date	20c. Location		
tim	it. Pag rtmen rtant riury		4 Donation 5 Other (Sp		Glen Have						e, MD 21061
Bal	permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev once.		21. Signature of Funeral Service Lic	. /	MO1357 S	Name and Addres	PA 1 2nd	ngleton Ave. SW	Funera Glen B	l & Cr urnie,	emation, MD 21061
			23a. Part 1. Enter the disease, or of shock, or heart failure. List on	omplications that caused the	ne death. Do not ente	r the mode of dying	g, such as cardiac	or respiratory a	rest,		Approximate Interval Between
P	Trysician/		Immediate Cause (Final disease or condition		ary ar	tery o	liscose				Onset and Death
	Medical Examiner		resulting in death)	Due to (or as a co	onse ce of):						
	_xammor	-e	Sequentially list conditions,	b. Due to (or as a c	annon and					_	
A.	ed nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	onsequence or,					-	
36	sate be executed physician and s the burial-transit	Exa	that initiated events resulting in death) Last	Due to (or as a c	onsequence of):						
99	s be e sicial e buri	ical		d							
376	ificate ig phy as th	Med	IF FEMALE:			- 19					
Box 687	requires that the death certifical been signed by the attending ph should be detached for use as the	Physician/Medical	23b. Was decedent pregnant in the past 12 months?		Fetal death 3		у			ate of deliver	
Bo	death	/sici	1 Yes 2 No	4 ☐ Pregnant at til 9 ☐ Unknown	me of death 5 L	Other (specify)			101	Ontri I	Day Year
0	at the d by t detach	Phy	Part II. Other significant condition	s contributing to death but	not resulting in the u	nderlying cause giv	ren in Part I.	23e. Did	obacco use con	tribute to the	e cause of death?
رن ت	res th signe d be d	d by						1 🗆	Yes 2 No	3 Prob	ably 4 🗆 Unknown
ğ	requi been shoul	Completed						24a. Was	an 24b.	. Were autop	sy findings available
oc o	e law e has age 2	d L						auto	psy prmed2 2 No	prior to condeath?	npletion of cause of
<u>~</u>	in: Th ifficate or, pa		25. Was case referred to medical	1		26. Pl	ace of Death (Chec		2 No	i li tes a	2 L NO
Vita	ysicia s cert direct	To Be	examiner? 1 D Yes 2 No	Hospital:	t 2 ER/Outpatier	nt 3 DOA Othe	er: 4 Nursing H	ome 5 X Res	dence 6 🗆 Ot	her (Specify)	
of	ng Ph ter th meral		27. Manner of Death 1 ▼Natural 5 □ Pending	28a. Date of injury (Month, Day, Y	28b. Time of injury	28c. Injury work	/ at ?	28d. Describe	how injury occur	rred	
ion	endir eath. or: Af the fu	ifica	2 Accident Investig	ation at the		M 1 🗆	Yes 2 No				
Division of Vital Records, P.O.	or Att	Certificate:	4 Homicide determine		- At home, farm, stre Specify)	eet, factory, office		28f. Location (City or To	Street and Numi vn, State)	ber or Rural i	Route Number,
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier 1 Certifying	Physician: To the best of my	y knowledge, death o	occurred at the time	e, date and place.	and due to the o	ause(s) and mar	ner as state	ıd.
	n 24 h	Medical	(Check 2 Medical Ex	kaminer: On the basis of examiner: To the basis of examiners are the basis of examiners.	mination and/or invest	tigation, in my opinio	on, death occurred a	at the time, date	and place, and d	ue to the cau	ise(s) and manner stated.
	To the vithing the complete co		29b. Signature and title of certifier			29c. License			29d. Date sign		
	12	1	Misneg	i , M.J.		D5	7531		Thatch	1 24,	2011
	C		30. Name and address of persen w	/ho completed cause of dea	th (Item 23a) (Type, F	Print)	*	*			16.0
			31. Date filed (Month, Day, Year)	32 Bagistrark	Signature	Hwy,	Mille	rsucy	e , //	10 2	8011
	Sta Registr		APR 0 3 2	2012 Zena	eterans s Signature	Kel					
			711 II V U								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #10e \$19b Per FH G926 4/13/2012 Jh. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 11:20P Theodore Allen Lear 2012 03 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Baltimore Washington Medical Center Glen Burnie Anne Arundel 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day, Year) Months Hours **Director** 215-30-1204 1 X M 2 □ F 80 09/25/1931 Maryland Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits death with the Maryland notified at **Funeral Director** 1 Yes 2 No Anne Arundel Glen Burnie 10e. Street and Number 906 10f. Zip Code ms 23a or must be n 10g. Citizen of What Country? 609 Phylen Court 21061 U.S.A. items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian. Examiner rmed Forces?

X Yes 2 \(\subseteq \) No Black, White, etc. ō þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 permit, Page 1 and 2 should be filed within 72 hours after 1 Yes 2 No Specify: If Yes, Give Year or Dates White "natural" Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Cryptologist NSA 12 Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Theodore Μ. Lear Marie Marmas Anna 19b. Spiles Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mrs. Gloria L. Lear / Wife 609 Phylen Court Glen Burnie, MD 21061 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Nourial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) MD Veterans Cemetery 04/03/2012 Crownsville, MD Signature of Funeral Service Licens 22. Name and Address of Facility 1 2nd Avenue SW MO1479 Glen Burnie, MD Singleton Funeral & Cremation Services, PA 23a. Part 1. Enter the disease, or complications that caused the death. Oo not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) **Examiner** renovar Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and burial-transit Due to (or as a consequence of): attending physician I for use as the buria Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year signed by the at Id be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 No this certificate has ral director, page 2 2 No 1 TYes 25. Was case referred to medical completely filled in by the funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 힏 1 Yes 2 No 1 Inpatient 2 KER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation 6 Could not be Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🖰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifi 29c. License number

Registrar
DHMH 17 Rev 06-2011

1600

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

03, 29, 2012

magrico du

Curtis Pearce Mei		I- For State	State	of Maryla		rtment of	f Health and f Death	d Mental I		Reg. No.	201	2 1027
Physiciar	1/	Registrar 1. Decedent's Name		•					2. Date of De	ath	Year	3. Time of Death
Medical Examin		Curtis Po			mh or\	- 1	4b. City, Town, or	Leastion of Dec	Month March 31		ounty of Deat	1405 hrs
A. A. C.		20732 Old Y		Ve street end nu	inber)		White Hall	Location of Dea	ui		imore Co	
Funeral	- 1	5. Social Security N			7. Age (In yrs. la	ast birthday)	If Under 1 Year		_		Forei	rthplace (State or
Director	Ź	219-34-77	36	X м 2 F	1	.8 Yrs	Months Days	Hours M	in. 09/30)/1993	Co	puntry) MD
any	-	Usual Residence of 10a. State	Decedent 10b. County		10c. City.	Town or Locat	ion	-				10d. Inside City Limits
		MD	Baltimo	re	Cock	keysvil	le ·					1 Yes 2 No
Aarylar 28a-f :	Director	10e, Street and Nun	nber				10f. Zip Code			10g. Citizen	of What Cou	ntry?
3a or		14529 Cul	ba Road				21030			USA		
death with the Maryland or items 23a or 28a-f show must be notified at once.	Funeral	11. Marital Status 1 X Never Marrie	ed 2 Marrie				s Decedent of Hisp es, specify Cuban,			0- 14.	Race - Amer White, etc.	ican Indian, Black,
fter de		3 Widowed		1 Yes d If Yes, Give Yaar	2 X No	1	Yes 2X No	specify:		Spe	ecify: Whi	te
iours a	<u>8</u>	15. Decedent's Ed			•	16a. Deceden	t's Usual Occupati ost of working life.	on (Give kind o			of Business/	
36 in 72 h	Completed	Elementary/Second	ndary (0-12)	College (1	-4 or 5+)	N/A	oot of working inc.	00 1101 430 11	, and any	N/A		
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	틹	17. Father's Name (First, Middle, Las	t)		11/11	1	8.Mother's Nan	ne (First, Middle,		name)	
215 be file ntal H.	n n	William S						Mereith				
MD 21215-0036 12 should be filed within 72 hours after th and Mental Hygiene. 1.27 is marked other than "natural". The Medical Examiner	- 4	19a. Informant's Na					Address (Street) Cuba Roa					
and 2 and 2 lealth item 2' traum		Villiam S 20a. Method of Disp	osition		20b. F	Place of Dispos	ition (Name of cem		Date		ation - City or	
imore, Pages I an nent of Hea ant: If ite	- 1	1 Burial 2			ill Otato	rematory or oth cro Cres	nerplace) matory,Ii	nc. 04	/03/2012	Balt	imore.	Maryland
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other transitie event, the Medical Examiner must be notified at one.	t	4 Donation 5 21. Signature of Fur	neral Service Lice	nseeStepha	anie Cus	ster 22. N	lame and Address	of Facility Cr.	emation	Socie	ty of	MD. Inc.
	V	23a. Part I. Enter the	u Ul		-	22	9 Freder	ick Roa	d Baltin	nore,M	arylar	nd 21228 Reproximate Interval
Physician Wedital	Ţ	failure. List only	y one cause on e	ach line.			le mode of dying, s	suci) as calqiac	or respiratory ar	rest, snock,	Of Healt	Between Onset and Death
xaminer		Immediate Cause (F or condition resultin	Final disease a ng in death)	Heroin Due to (or as a	consequence of							
		Sequentially list con		-	consequence of	١-						
	≣I.	cause. Enter Under	rlying Cause									
cuted nnd transit	LX	events resulting in c		Due to (or as a		•						
oe exe ician 2		X UNPENDED		AMENDED	23a,27,2	28a-f,p	er me,g9	26 4–9–	12 sm			
Box 68760 re death certificate by the attending physi red for use as the bu		F FEMALE: 3b. Was decedent p		23c. If yes, o	outcome of pregn		tal death 3	Ectopic pregr	nancy	23d. Da Moi	ate of deliver	y Day Year
x 60 th cert ttendin r use a		past 12 months?		4 Pregna	ant at time of dea	-th -	ner (Specify)					
C. Boy t the death by the att	≥L	Part II. Other signifi		9 Ulkilo		sulting in the u	nderlyino cause di	ven in Part I	23e Did t	obacco use	contribute to	the cause of death?
ires that the signed by the detach	2			contributing to	dodar bacriot ro	outing in the u	ndonying ozdoo gi	voir iiri die i.				pably 4 🗹 Unknown
cords,									24a. Was			topsy findings available completion of cause of
Records, The law requires ficate has been sign, page 2 should be								_		rmed?	death?	
tal Records cian: The law requi certificate has been ector, page 2 should		25. Was case referre		0 37				of Death (Chec				
Physic ral dire	2		2 No	Hospital: 1 1 1r		ER/Outpatient 28b. Time of Ir		at Work?	ing Home 5			r: Scene
On O		1 Natural	5 Pending	(Month,	Day,Year)	fd 01:5		es 2 🗶 No	unknown		-	
Division of Vital Records, P.O. Ital or Attending Physician: The law requires that the star after death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach.	2	2 Accident 3 Suicide	Investigate 6 X Could not	ION 280 Place			et, factory, office bu	ilding, etc.	28f. Location (Street and N	Number or Ru	ral Route Number, City
Division o spital or Atteodiog nous after dealh or actual Director: After filled in by the fune	5 3 -	4 Homicide	determine	ed (Specify)	Found: Re	esidenc	е		White	lall,M	D.	TOTE RG.
Division of Vital Records, P.O. Box 68760 To the Hospital or Atteodiog Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the beautiest of the formal directory.	<u> </u>	(Check only		r:On the basis o	f examination an		red at the time, dat ion, in my opinion,					
1 × 1 × 1	Ē	29b. Signature and t		and manner st	ated.		29c. License	number		29d. Date	signed (Mo.	nth, Day, Year)
		Li	y hu				O.C.M	1.E.		April 1,	2012	
	1	30. Name and addre					e Street, Balti	more MD 2	1223			
Stat	e :	31. Date filed (Month			gistrar's Signatur		- 4					
Registra	il	LPR	Q 3 2012	Bur	m A.	par						
DHMH 17 Rev 1/200	1	244 6		*	,	ORIGINAL	L		008	AF		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#16a, 19a, perFH, G926, 4/37 2012, WS

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Kevin Bryan Morris, Sr. Physician/ 12:34 PM MARCH 2012 Medical 4a. Facility Name (if not institution, give street and number)
7861 Mansion House Crossing Town, or Location of Death Pasadena 4c. County of Death **Examiner** Anne Arundel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Social Security Number 214-68-6472 (Month Day Year) 8/14/57 1**XX**M 2 □ F 54 Virginia **Director** Yrs. Usual Residence of Decedent 10d. Inside City Limits 10a, State 10c. City, Town or Location items 23a or 28a-f sho her must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland Director Anne Arundel Pasadena MD 1 Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 7861 Mansion House Crossing 10f. Zip Code 21122 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. 11. Marital Status "natural", or itel dical Examiner Armed Forces? Black, White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black 1 Yes 2XXNo Specify: If Yes Give Completed 3 Widowed 4 Divorced Year or Dates 16b. Kind of Business/Industry Aviational Aeronautics and Radar 15. Decedent's Education 16a. Decedent's Usual Occupation permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ne
any injury or other traumatic event, the Medic (Give kind of work done during most of working (Specify only highest grade completed) life. DO.NOT use relied Principle Electrial Engineer College (1-4 or 5+) Elementary/Secondary (0-12) 12 5+ Electrical Be 17. Father's Name (First, Middle, Last)
Alvin R. Morris, Sr. 18. Mother's Name (First, Middle, Maiden Surname) EUNICE M. FISHER ပ္ 19a. Informant's Name/Relationship (Type, Print)

Morris / Wife 19b. Mailing Address (Street and Number or Bural Route Number, City or Town, State, Zip Code). 7861 Mansion House Crossing, Pasadena MD 21122 Rosetta 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)

Peacefulrest Cemetery 1 🔲 Burial 2 🗆 Cremation 3 🖾 emoval from State 3/21/12 Thomasville, Georgia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee V1CLOR P. Doda Charled to Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore Maryland 21230 TO 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ASPIRATION Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury MENASTAN the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last physician Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death 9 Unknown 9 Unknown signed by d Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Hypenuligers 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed' death? 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director, Other: 4 Nursing Home 5 N Residence 6 Other (Specify) 2 1/2 No ဂ္ 1 \square Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No n 24 hours after death.

e Funeral Director: A sletely filled in by the fu Accident Investigation 2 ☐ Acciden 3 ☐ Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho
To the Fune
completely f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one) 29c. License number D-22609 29b. Signature and title of certifier MARCH-14-2012 1280 Name and address of person who completed cause of death (Item 23a) (Type, Print) FORNACE BRANCH Rd 6LEN BURNIEMB-21060 -7445 32. Registrar's Signature State Registrar

			Please Type or Print in Blac amend #5,9,11,12,15,16a&b,17,18 State of Maryland / D	k Indelible Inl 19a&b ,20a-c Department of F	k. Ensure A &22 Per F Health and M	II Copies A H G926 4 Mental Hygie	re Legible	e Jh
	Physicia	ın/	Decedent's Name (First, Middle, Last)	Certificate of L		2. Date of Death Month	No. 2012	3. Time of Death 12:40 P M
	Medic Examin		Shirley Ann Mitchell 4a. Facility Name (if not institution, give street and number) 110 W. North Avenue	4b. City, Town, or Baltim	r Location of Death	March 26	4c. County of De	
4	Funeral Director		5. Social Security Number unk 6. Sex 7. Age (In yrs. last birth		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye Jan 6, 1	960 De	Birthplace (State or Foreign Country) unk elaware
	Maryland Ba-f show tifled at	rector	10a. State 10b. County 10c. City, Town Balti					10d. Inside City Limits
	s 23a or 2 ust be no	Funeral Director	10e. Street and Number 110 W. North Ave.	10f. Zip Code 21218	}	10g	j. Citizen of What (USA	Country?
036	permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. In an anotative the T is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Statusunk XX Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. unk Armed Forces? 1 Ves XX No If Yes, Give Year or Dates.	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 1 No		ecify Yes or No- Rican, etc.)	14. Race - An Black, Wh Specify: B1	nerican Indian, nite, etc. .ack
Maryland 21215-0036	vithin 72 houliene. Iene. Ir than "natu	Completed	(Specify only highest grade completed)	Decedent's Usual Occup (Give kind of work done of life. DO NOT use retired)	pation unk during most of worki	ng		eparation
yland ?	ld be filed v Mental Hyg arked othe atic event,	To Be	17. Father's Name (First, Middle, Last)—unk Sammy Robinson	5.50%		e (First, Middle, Maio Mitchel	den Surname) un	
, Man	nd 2 shoul salth and I n 27 is ma er traums		19a. Informati's Nague Settionship Troother Officer Callow - BCPD	1942d Fæi≯vi 500 E. Balt	ecwour§5FrorAvi	Rentown 91 Baltimor	PA 748192 e, MD 21	Zip Code)
Baltimore,	t. Page 1 ar tment of He rtant: If iter ijury or oth		1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ☐ 11 State Gree	Disposition (Name of c, crematory or other place nwood Cemet	ery 4/02/	'2012 A		,PA 18104
Ba	Depar Impo Impo any ir		21. Signature of Fune Service Lice Service Lice Director 23a. Part 1. Enter the disease, or complications that caused the death. Do not not not not not not not not not no	W. 1	baltimore	ot, balt	y Board Ba imore, St	1211 Chesaco 1to MD 21237 aryland 2120
	Medicale be executed attending physician and attending physician and after use as the burial-transit	dical Examiner	shock, or heart failure. List only one cause on each line. Immediate Sause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Early Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Cause (Disease or injury that initiated events resulting in death) Last	n: Sufficien	cy			Approximate Interval Between Onset and Death
Box 68/60	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. Within 25 hours after death, the conficient has been signed by the attending physici to the Luneral Director. After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the but the completely filled in by the funeral director.	Physician/Medica	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	cy		23d. Date of o	delivery Day Year
ds, P.O.	quires tnat ur en signed by buld be deta	by	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given	ven in Part I.			to the cause of death? Probably 4 Unknown
Recor	Physician: The law ree this certificate has be ral director, page 2 sho	Completed	A-h b Ashma 25. Was case referred to medical	00 D	The second Possible (Observe)	24a. Was an autopsy performe	prior to death	autopsy findings available o completion of cause of ? //es 2 No
T VITA	Physicia this certi al directi	: To Be	examinar? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Out 27. Manner of Death 28a. Date of injury 28b. Til	patient 3 DOA Othe	4 U Nursing Ho	me 5 Residenc		ecify)
Division of Vital Records,	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director. After thi completely filled in by the funeral	Certificate:		jury work M 1 □	Yes 2 No	28d. Describe how i 28f. Location (Stree City or Town, S	t and Number or F	Rural Route Number,
۵	the Hospitai hin 24 hours i the Funeral I	Medical (29a. Certifier 1 Certifying Physician: To the best of my knowledge, di Check 2 Medical Examiner: On the basis of examination and/or only one) 3 Certifying Nurse Practitioner: To the best of my knowledge.	investigation, in my opinio ledge, death occurred at t	on, death occurred at the time, date and pla	the time, date and p	lace, and due to th	e cause(s) and manner stated
D	North Solution		29b. Signature and title of certifier	19.	57890	29d	Date signed (Mor	nth, Day, Year)
	, CI		30. Name and address of person who completed cause of death (Item 23a) (Ty Shavin Libetti CRNP Z(00) 31. Date file (1874) (2014) (2014) 32. Registrar's Sanature	N. North F	tve Bal	timme 1	MD 21	216
	Stat Registra		31. Date file Appril Pag 92012 32. Registrar's Sgnature	Ked				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1740 Marcin SHAVE Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 212-49-5945 **Director** 1 X M 2 🗆 F 15yrs. Mary1and 10/18/1996 show 10a. State the Maryland notified at 10c, City, Town or Location Director 10d. Inside City Limits 28a-f Md. Carrol1 Marriottesville 1 ☐ Yes 2 X No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a 1896 Rockridge Ct. 21104 USA items be filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. event, the Medical Examiner Was Decedent Ever Armed Forces? 1 ☐ Yes 2 🕱 No Black, White, etc. 1 X Never Married 2 Married ō by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 'natural", 3 Widowed 4 Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry id Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 10vrs. Student Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Ronald McGinn Dianne Frisch other traumatic and l 19a. Informant's Name/Relationship (Type, Print) . 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Ronald McGinn (Father) 1896 Rockridge Ct. Marriottesville, Md. 21104. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Good Shepherd 04/03/2012 Howard County, Md. Signature of Fundamental Service Licensee 22. Name and Address of Facility Haight Funeral Home & Chapel Box 195 Sykesville, Md. 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Examiner Some dially list as well use if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine that the death certificate be executed that initiated events resulting in death) Last burialphysician Physician/Medical Box 68760 the IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy for in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Pregnant at time of death Day Year the 9 Unknown g | Unknown P.O. | à been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Hospital or Attending Physician: The law requires Completed 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performed? 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 No. Other: မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Man of Death Certificate: 28b. Time of 28c. Injury at work? 1 \(\sum \) Yes 28d. Describe how injury occurred Natural iniury 5 Pending iours after death.

neral Director: Ai 2 | No 2 Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier within 24 hor To the Fune completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the only on 29b. Signatu and title of certifier 29d. Date signed (Month, Day, Year) March 30, 201

DHMH 17 Rev 06-2011

State

Registrar

and address of pe

APR 0 3 2012

31. Date filed (Month, Day, Year)

N. Wolfe St Baltimore MD 21287

600

rsen who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

raue

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2<u>012</u> Physician/ Month Thurman Paul Martin March 30 1:40 p Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 3501 Forest Edge Drive Silver Spring Montgomery Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1**X**] M 2 □ F Months Min (Month, Day, Year) ec 21, 1936 Hours 218-34-7396 75 Director Virginia Usual Residence of Decedent show 10a, State 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland aţ Director notified MD Silver Spring 1 Yes 2 No 28a-f Montgomery 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? other traumatic event, the Medical Examiner must be Completed by Funeral 23a 20906 3501 Forest Edge Drive #1A USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2X No Specify. If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Brick Mason Foreman Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Millie Wilder Ray Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3501 Forest Edge Dr. #1A Silver Spring, MD 20906 Barbara B. Martin/wife f Health aitem 27 i 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or oth 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Final Journey Crematory 04/03/12 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Going Home Cremation Service P.O. Box 784 MO1251Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ a Parkinson's Disease disease or condition Medical resulting in death) **Examiner** Dementia Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events Renal Failure and resulting in death) Last Due to (or as a consequence of). Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Rhabdomyolysis Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Day Year 1 Yes 2 L 9 Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 \square Yes 2 \square No 3 \square Probably 4 \square Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed? Yes 24 No 2 🗆 No 1 🗌 Yes To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?

1 Yes 2 XNo Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5X Residence 6 ☐ Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? Certificate: 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending injury 1 Tyes 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, geath occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) March 31, 2012 D37142

State Registrar

DHMH 17 Rev 7/2009

31. Date filed (Month

ame and address of person who completed cause of death (Item 23a) (Type, Print)

Coleman, M.D. 1355 Piccard Drive Rockville, MD 20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 28, Day 2012 Year 8:40 P M Fred Winfield Magruder Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery 25113 Silver Crest Drive Gaithersburg Social Security Number Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 🕅 M 2 🗆 F Feb 7. Months Days Hours Min 1938 215-36-3054 74 **Director** Maryland Usual Residence of Decedent 28a-f shov 10a. State 10b. County death with the Maryland iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2X No MD Montgomery Clarksburg 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 24901 Stringtown Road 20871 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2x No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates. 1958–63 injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Field Technician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I 2 Harry Magruder Ola Lowry 1 and 2 should by Health and Meitem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Timothy W. Magruder/son 25113 Silver Crest Drive Gaithersburg, MD 20882 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) Final Journey Crematdry 03/31/12 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) Signatur of Funeral Service Licens Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the Usease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fillure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Creutzfeldt-Jakob Disease Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate Due to (or as a consequence of) physician and the burial-transit Cause (Disease or linjury the Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 ending pure IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

December 1 Fetal death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes Other: 4 Nursing Home 5 Residence 6 X Other (Specify 2 [**X**No Hospital son 's ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: XNatural injury 5 Pending work?
1 Yes 2 No Accident Investigation M Suicide 6 Could not be within 24 hours after de

To the Funeral Directo

completed filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🛮 🗶 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State Registrar 29b, Signature and title of certifie

31. Date filed (Month, Day, Year)

30. Name and address of person who comple

ne and address of person who completed cause of death (Item 23a) (Type, Print)

Coleman, M.D. 1355 Piccard Drive Rockville, MD 20855

29c. License number

D37142

29d. Date signed (Month, Day, Year) March 30, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 20b, per fh, g926 4-3-12 sm State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Physician/ 2012 Medical acility Name (if not institution, give street and number) City, Town, or Location of Death County of Death **Examiner** Baltimore Christ OWSON Hospice If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months (Month, Day, Year) 216-28-3482 Country) Director 1 □ M 2 💢 F 0 7-16-1907 Usual Residence of Decedent 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director Baltimore 1 Yes 2 No MD 10e. Street and Number 10g. Citizen of What Country? Completed by Funeral 村10 akewood Ave. items ? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 12. 11. Marital Status 14. Race - American Indian, ?7 is marked other than "natural", or iten traumatic event, the Medical Examiner Armed Forces?

1 Yes 2 No if Yes, Give Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Black Specify: 3 XWidowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) ygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Johnson Carrie Howard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glenmore Baltimoje. ohnisha erspoon-Niece 4008 MO 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 Department of I Important: If it any injury or o' XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) emetery 1timore 22. Name and Address & Facility March F/H-East 1101E: North Ave Baltimore, MD 21202 21. Signature of Funeral Service Licensee Brank Mil 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Physicum/ neumonia. Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): as the burial-transit law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: nse 8 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day Year the 1 Li Yes 2 Li 9 Li Unknown Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? signed Completed by chronic kidney disuse 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page 2 performed 2 No 1 Yes Yes 25. Was case referred to medical Hospital or Attending Physician: completely filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Hospital Other: ပ္ 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 🔊 Other (Specify) 🚧 Š 🌣 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 1 Natural 28d. Describe how injury occurred the Funeral Director: After (Month, Day, Year) 5 Pending injury death. ☐ Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) within 7 ture and title of certifier 29b. Sia License number 29d. Date signed (Month, Day, Year) MARCHI 26 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HARLES 6701 ronces NO2 ENST N. M 31. Date filed (Month, Day, 32. Registrar's Signature State APR 03 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #23 Per PHY G926 4/10/2012 JH State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 Year Month Day Helen Barbara McKeown March 31 6:50 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Renaissance Gardens Silver Spring Prince George's Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth Months Min (Month, Day, Year) 037-16-1502 Hours **Director** 1 □ M 2 🛛 F Yrs. 87 July 2, 1924 Rhode Island Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or item. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Montgomery 1 Yes 2 X No Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10714 Great Arbor Drive 20854 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Yes Yes, Give 1 Yes 2 No Specify. Specify: White Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) 5+ Elementary/Secondary (0-12) Registered Nurse Health Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Luke F. Seery Josephine C. Quinn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan M. Reutershan / Daughter 10714 Great Arbor Drive, Potomac, Maryland 20854 20b. Place of Disposition (Name of Cemetery, crematory or other place)
Montgomery
Crematorium, Inc. 20a. Method of Disposition 20c. Location - City or Town, State Date April 3, 1 \square Burial 2 X Cremation 3 \square Removal from State 4 Donation 5 Other (Specify) Bethesda, Maryland Signature of uneral Ser Robert A. Pumphrey Funeral Home, Rockville, 300 W. Montgomery Avenue, Rockville, Maryland, once. M01619 23a. Part 1. Enter the disease, or complications that caused the death.
shock, or heart failure. List only one cause on each line.
Immediate Cause (Final Pancreatic Cancer

Traces of: complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate in Approximate set an Death Ph_{sician} MOIILIIS Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): Due to (or as a consequence of) attending physician a for use as the burialresulting in death) Last Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?

1 Yes 2 X No 4 Pregnant 9 Unknown Month Pregnant at time of death Day Year ed by the a detached t Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed 23e. Did tobacco use contribute to the cause of death? þ should be Bronchiectasis Be Completed 1 Yes 2 No 3 Probably 4X Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an s certificate has the autopsy performed? Yes 2 X No the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes Other: 4 X Nursing Home 5 - Residence 6 - Other (Specify) 2 🛛 No ျှ 1 Inpatient 2 ER/Outpatient 3 IDOA this Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred After X Natural 5 Pending injury within 24 hours after death To the Funeral Director: A Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completely Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of cer 2 29c. License number 29d. Date signed (Month, Day, Year,

Registrar
DHMH 17 Rev 06-2011

State

30. Name and address of person who completed cause of

APR 0 3 201

31. Date filed (Month, Day, Year) .-

Mark Parkhurst, M.D. 3110 Gracefield Road, Silver Spring, Maryland 20904

death (Item 23a) (Type, Print)

D24093

April 2, 2012

*			101	Department of Health and	Mental Hyg	iene	10000
		_1	State Registrar	Certificate of Death		eg. No. 2012	10280
Ph	ysicia		1. Decedent's Name (First, Middle, Last)		2. Date of Deatl Month 03		3. Time of Death
	Medic	ai -	Elizabeth S. McIntee 4a. Facility Name (if not institution, give street and number)				5:30 P M
} □	xamin	er '	2113 HAVEN OAK COURT	4b. City, Town, or Location of Dea ABINGDON	ith	4c. County of Death HARFORD	
Fu	neral		5. Social Security Number 6. Sex 7. Age (In yrs. last bi	rthday) If Under 1 Year If Under 24 Hr		9. Birth	place (State or Foreign
	ector		229-38-3918 1□M2XF	Yrs. Months Days Hours Mir	1		
ъ	t o		Usual Residence of Decedent 79 10a. State 10b. County 10c. City. Toy	vn or Location	11/23/1		INIA 10d. Inside City Limits
ırylan	ied a	cto					1 🗆 Yes 2 🛣 No
he Ma	notil		MD HARFORD ABING 10e. Street and Number	GDON 10f. Zip Code	1	Og. Citizen of What Cou	
with t	st be	eral	2113 HAVEN OAK COURT	21009		USA	
eath	er mt	Ē	11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue		14. Race - Ameri	
ifter 6	turar , or items zoa or zoa-i snow al Examiner must be notified at	र्	1 Never Married 2 X Married Armed Forces? 1 Yes X No If Yes, Give	1 Yes 2 X No Specify:	no moan, etc.)	Black, White, Specify: WHIT	
15-UU36 72 hours after death with the Maryland	al Ex	Completed	3 ☐ Widowed 4 ☐ Divorced Year or Dates.				
1215-0036 hin 72 hours after ne.	the Medical	du l	(Specify only highest grade completed)	 a. Decedent's Usual Occupation (Give kind of work done during most of w life. DO NOT use retired) 	orking	16b. Kind of Business/Ir	
E = 5	the I		Elementary/Secondary (0-12) College (1-4 or 5+)	OMINISTRATOR		VALVE EQUIF	MENT CO.
al Hyg	otner event, ti	Be	17. Father's Name (First, Middle, Last)	18. Mother's N	ame (First, Middle, M	flaiden Sumame)	
yla Ild be Ment	marked otner	욘	ROBERT MONTGOMERY	CORNIE	LOFTICE		
ਲ ਲ	ar 18	1		b. Mailing Address (Street and Number or F 2113 HAVEN OAK COURT			Code)
	other 1	-		of Disposition (Name of		20c. Location - City or 7	own State
Page 1	<u> 1</u>		1 🕅 Burial 2 □ Cremation 3 □ Removal from State cemet	tery, crematory or other place)		FALLSTON, M	
₽ ∴ ₹ 1	injury o	1	21. Signature of Funeral Service Licensee	22. Name and Address of Facility			
De la constant	any in	-	Warnick	610 W. MACPHAIL R			
			23a. Part . Enter the disease, or complications that caused ty de th. Do shock, or heart failure. List only one cause on each line.	ong enter the mode of dying, such as caldi	ac or respiratory arre	st,	Approximate Interval Between
· Physi			Immediate Cause (Final disease or condition	remers al	stace		Onset and Death
	edical niner		resulting in death) Due to (or as 1 consequence	of):	2/1	0	7 10 002 0
		er	Sequentially list conditions, if any, leading to immediate b. Due to (or as a con equence	on:	y ans	lase	1 10 year
. р	nsit	Examiner	ranny, leading to immediate Due to (b) as a configuration cause. Enter Underlying Cause (Disease or injury	Metelmin	J		> 11 island
y xecut	burial-transit	Exa	that initiated events c. Due to (or as a consequence	of):			10 5/1-03
te be ex	ysicia ne bur	dical	d				
certificat	as th	Mec	IF FEMALE:				
th cer	or use	ian/	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy			23d. Date of deli	very Day Year
Box e death o	thed f	Physician/Me	1 ☐ Yes 2 ☑ No 9 ☐ Unknown 4 ☐ Pregnant at time of death	5 U Other (specify)		World	Day real
P.O.	should be detached for use as the		Part II. Other significant conditions contributing to death but not resulting	g in the underlying cause given in Part I.	23e. Did tob	pacco use contribute to	the cause of death?
S, Lires t	ed blu	ed by	hyperchallste	willing	_ 1 🗆 Ye	es 2 No 3 Pro	obably 4 Onknown
Orc Wreque	s Deel	plete			24a. Was a		opsy findings available
Records, The law requires	age 2	Completed			– autops perforr 1 ☐ Yes		ompletion of cause of
ian: T	ctor, p	Be C	25. Was case referred to edical examiner?	26. Place of Death (Ci		2.010	
hysic	al dire	မ	1 Yes 2 No Hospital:		Home 5 Reside	ence 6 Other (Specia	(y)
ling P	funera	Certificate:	1 atural 5 Pending (Month, Day, Year)	. Time of 28c. Injury at work?	28d. Describe ho	w injury occurred	
SION	y the	tific	2 Accident Investigation 3 Suicide 6 Could not be 4 Despisite detailed 28e. Place of Injury - At home,	M 1 Yes 2 No	28f Location (St	reet and Number or Run	al Route Number
Division of Vital tal or Attending Physician: rs after death.	d ii b		4 Homicide determined 200. Place of Injury - Actionie, building, etc. (Specify)		City or Town		arriodico riamisor,
Division of Vital Records, P.O. To the Hospital or Attending Physician: The law requires that the within 24 hours after death.	unera	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge	e, death occurred at the time, date and place	e, and due to the cau	use(s) and manner as sta	ited.
the H	nplete	Med	(Check 2 ☐ Medical Examiner: On the basis of examination and only one) 3 ☐ Certifying Nurse Practitioner: To the best of my kn	owledge, death occurred at the time, date and			
- F . ₹ 5	9 00		29b. Signature and title of certifier	29c. License number	77 2	9d. Date signed (Month)	Day, Year) 2017
	6		100,1000,110	5 5 6	200		10/2
-	U		30. Name and address of person who completed cause of death (Item 23a	LIVE FLUMTREE ,	W., 841	IE IJ BE	I HIR, MI
	Stat	e	31. Date filed (Month, Day, Year) 32. Registrar's Signature	7			2/015
R	egistra		APR 0 3 2012 Canela B. A	rave			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 3 Physician/ MEKCER EBORAH 0330 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE Anne Arunde 5301 WASENA AVE 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday **Funeral** Director 1 □ M 2**X** F 28a-f show 10a. State 10c. City, Town or Location injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No 10g. Citizen of What Country? ò Funeral 2. S. A. or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S 14. Race - American Indian 11 Marital Status Armed Forces Black, White, etc. 1 Never Married 2 Married ò ☐ Yes 21215-0036 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates Specify Hygiene. other than "natural", 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) is marked other Be Maryland Mother's Name (First, Middle, Maiden Surname, Father's Name (First, Middle, Last) ပ Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number Department of Health a Important: If item 27 is any injury or other traces MD. ZIZZS Baltimore, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State -29-12 4 Donation 5 Other (Specify) ODENTON, MO. paheaty funeral Home 2601 MOUNTAIN RD. 23a. Part 1. Enter the discase of shock, or heart failure. List or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death BRAIN Physician/ GLIOBLASTOMA disease or condition resulting in death) rears Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical death certificate be 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box (Live Birth 2 Live Birth 2 Pregnant at time of death 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown detached for Month Day Year 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy certificate 2 No 2 X No 1 🗌 Yes Yes 25. Was case referred to medical examiner? Division of Vital Be 26. Place of Death (Check only one) Hospita 2 No Other: ပ္ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Physical Within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral directors. 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural injury work? 5 Pending 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month Day, Year) 3 D003658 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 29 Joseph Michael Monaghan 5:51 A. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Power Back Rehabilitation Center Lutherville **Baltimore** 5 Social Security Number . Age (In yrs. last birthday) 57 Yrs. If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 € M 2 □ F Months Days Hours January 11, 1955 217-58-8148 Director Mar^{co}lland Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. Count 10a, State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Towson 1 Yes 2X No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21286 USA 1656 Aberdeen Road 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces Black, White, etc. þ 1 X Never Married 2 Married Maryland 21215-0036 Yes 2 X No If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: 3 Divorced Specify: White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72, and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Grocery Store Worker Giant Food other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas C. Monaghan, Sr. Beverly Irwin permit. Page 1 and 2 should I Department of Health and Me Important; If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3723 Raspe Avenue Baltimore MD 21206 Kathleen Rathell/Sister Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
New Cathedral Cemetery Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) any injury or 3/31/12 Baltimore MD 21. Signature of Funeral Service Licenses Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road Baltimore MD 23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause on e Approximate Interval Between Onset and Death aused the death. po not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this country. burial-transit Cause (Disease or injury that initiated events physician and s the burial-trans Due to (or resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) for in the past 12 months? Pregnant at time of death Month Day 2 No be detached 9 Linknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Soknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy page perform Yes 2 25. Was case referred to medica funeral director, Be 26. Place of Death (Check only one) examiner? Hospital 2 No ျပ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work?
1 Yes 2 No I Director: ₽ Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, the peath occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: Of the basis of examination and/or/investigation, in my opinion, death occurred at the time, date and place, and due to the cause 29a. Certifier 2 Medical Examiner.
3 Certifying Nurse P of the basis of examination and/of investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated ractioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0042736 30. Name and address of person who completed dause of death (It 1734 York 21093 Avman Akkad State Registrar

		-	4	epartment of Health and N Certificate of Death		ene	2 10283					
	Physicia Medic		1. Decedent's Name (First, Middle, Last) Anna E. Neufeldt		2. Date of Death March 29,		3. Time of Death 6:10 A M					
	Examin		4a. Facility Name (if not institution, give street and number) Roland Park Place	4b. City, Town, or Location of Death Baltimore		4c. County of Dear N/A						
	Funeral Director			day) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,) March 10,	rear) Co	thplace (State or Foreign untry) nsas					
	ryland I-f show ied at	Director	Usual Residence of Decedent 10a. State	or Location Baltimore			10d. Inside City Limits 1 XX Yes 2 □ No					
	the Ma or 28s	Dire	10e. Street and Number	10f. Zip Code	10	Dg. Citizen of What Co						
	th with	Funeral	830 West 40th Street	U.S.A.								
920	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 XXNever Married 2 Married 1 Ves 2 XXNo									
21215-0036	thin 72 hou ne. than "natu ne Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Flementary/Secondary (0-12) College (1-4 or 5+) Sal	/Industry								
land 2	be filed wit ental Hygie ked other ic event, th	To Be (17. Father's Name (First, Middle, Last) Jacob Neufeldt	18. Mother's Nam Katy Bo		aiden Surname)						
, Maryland	d 2 should raith and M m 27 is marer traumat	ř		Mailing Address (Street and Number or Rura 346 Marina Drive Berlin,		City or Town, State, Zi	p Code)					
Baltimore,	Page 1 an ment of He ant: If iten ury or oth		1 Burial 2 XXCremation 3 Bemoval from State cemetery	c Crematory or other place) Crematory 3/30	/12	20c. Location - City or Glen Burnie,	MD					
Balt	permit. Departi Import any inj		21. Signature of Euneral Stervice Incenses	22. Name and Address of Facility Furg 3631 Falls Road Baltim		eitz Funeral 1211	Home, Inc.					
	Pnysician/ Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a	Dementia	or respiratory arres	st,	Approximate Interval Between Onset and Death					
90	be ex siciar buris	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of									
P.O. Box 6876	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of de Month	olivery Day Year					
ls, P.O	uires that the signed by ald be deta	ed by Pi	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tob	acco use contribute to	o the cause of death? Probably 4 Unknown					
Division of Vital Records,	The law requate has bee bage 2 shou	Completed by	DIABETES Melli	tus Type 2	24a. Was an autopsy perform	prior to death?	utopsy findings available completion of cause of					
ita	ician: 1 certifica rector, 1	Be	25. Was case referred to redical examiner? 1 Yes 2 W No Hospital:	26. Place of Death (Check	conly one)							
of V	ig Physical dispersal di	te: To	27. Manner of Death 28a. Date of injury 28b. Ti		me 5 ∐ Resider 28d. Describe hov	nce 6 Other (Special Notice of Control of Co	cify)					
vision	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certificate:	1 Matural 5 Pending (Month, Day, Year) in 2 Accident Investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, fan building, etc. (Specify)	M 1 Yes 2 No	28f. Location (Str. City or Town,	eet and Number or Ru State)	ural Route Number,					
۵	To the Hospital of within 24 hours a To the Funeral D completely filled in	Medical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, d (Check 2 Medical Examiner: On the basis of examination and/or	investigation, in my opinion, death occurred a	the time, date and	d place, and due to the	cause(s) and manner stated.					
	To the within 2 To the comple	ž	only one) 3 Certifying Nurse Practitioner: To the best of my know 29b. Signature and title of certifier	/ledge, death occurred at the time, date and plantage and plantage and plantage and plantage are set of the control of the con		cause(s) and manner and cause(s) and manner and cause(s)						
	•		> Laray on mo	D35102	(narch 2	9.2012					
7			30. Name and address of person who completed cause of death (Item 23a) (The state of the state o	th CHAVLES STRUCT	Baltim	ore mar.	lano					
	Stat Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signature APR 0 3 2012	ale								

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year 20<u>12</u> Xuven Ngo April 8:30 A.M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Collingswood Nursing & Rehab. Center Montgomery Rockville Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Hours 1 □ M 2 😿 February 7, Director 99 578-13-0650 ″1913 China Usual Residence of Decedent 28a-f show 10b. County ms 23a or 28a-f shor must be notified at 10a State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10355 Green Holly Terrace 20902 China or items within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No 11. Marital Status 2 should be filed within 72 hours after deat th and Mental Hygiene. 27 is marked other than "natural", or iten traumatic event, the Medical Examiner I 14. Race - American Indian þ 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced Specify: Completed Asian Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Ox Ngo Silver Kwong 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s f Health a item 27 i San Diep / Granddaughter 8511 Century Oak Court, Fairfax Station, VA 22039 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or oth 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery April 4, 2012 Silver Spring, Maryland 22, Name and Address of Facility Robert A. Pumphrey Funeral Home, Rockville, Inc. 300 W. Montgomery Avenue, Rockville, Maryland 20850 M01619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Dementia disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Anemia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated events Due to (or as a consequence of) Exami requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of): burialphysician the burial Physician/Medical P.O. Box 68760 as t attending IF FEMALE: nse s 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 X No Month Pregnant at time of death Day Year 1 Yes 2 2 9 Unknown the a Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 \square Yes 2 \boxtimes No 3 \square Probably 4 \square Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an or Attending Physician: The law certificate has autopsy performed?
1 ☐ Yes 2 🛣 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 ី No Hospital 1 Tyes Other: ဂ္ဂ 1 Inpatient 2 ER/Outpatient 3 I DOA 4 X Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death nours after death. neral Director: After that filled in by the funeral 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🕅 Natural (Month, Day, Year) 5 Pending work? 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral I To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year)

3 m

Rita Ghosh,

DHMH 17 Rev 7/2009

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

D30132

14812 Physicians Lane # 161, Rockville, Maryland 20850

April 2, 2012

		F	Please	Type or F	rint in	Blac	k Indelil	ble Inl	k. Ensure	All Copie	es Ar	e Legi	ble.			
		For		State of	Maryla				lealth and	Mental H	ygiene	e	10	1000	-	
		State Registrar	Certificate of Death					Reg. N	16	1028						
Physicia	n/	1. Decedent's Name (First, Middle, Last)					-1-				Death	Year	3. Time of Death 6:20 P M			
Medic		John M. O'De						nne11 4b. City, Town, or Location of Death								
Examin	er	6006 Walton Road				Bethes				Montgomery						
Funeral		5. Social Security Number	6. Se		Age (In yrs	. last birth	day) If Unc	der 1 Year	If Under 24 Hr		Birth Day, Year)			lace (State or Foreign	7	
Director		Usual Residence of Decedent			91	91 Yrs.				Septemb				w York		
and show	or	10a. State 10b. Co					or Location			T-F			1	0d. Inside City Limits		
Maryl. 28a-f otifiec	Funeral Director	Maryland Montgomery				Bethesda						1 ☐ Yes 2 💢 N				
h the	al D	10e. Street and Number				10f. Zip Code						itizen of W		-		
th wit ms 2; must	ner	6006 W	alton	Road 12. Was Decede	-4 Fi- I	1.0	10 W D		20817			Unite			_	
er des or ite miner	by Fi	Armed Forces? 1 ☐ Never Married 2 ☒ Married 1 ☒ Yes 2 ☐			es?	If Yes, specify Cuban, Mexican, Puerto R					ity Yes or No- ican, etc.) 14. Race - American Indian, Black, White, etc.					
ırs aft ıral", İ Exal	ted k	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates.				WII	Specify: White									
72 hou "nate	Completed	15. Decedent's Education (Specify only highest grade completed)				16a. Decedent's Usual Occupation (Give kind of work done during most of work					king 16b. Kind of Business/Industry					
ithin 7	Con	Elementary/Secondary (0-12) College (1-4 or 5+) 5+			or 5+)	life. DO NOT use retired) Lawyer				Department of Justic						
iled w Il Hygi othe	Be	17. Father's Name (First, Middle, Last)				· · · · · · · · · · · · · · · · · · ·				me (First, Middle, Maiden Surname)					_	
d be f Menta arked atic er	유	Michael Kieran O'Do					nne11				Mary Howard					
shoul and is m		19a. Informant's Name/Relationship (Type, Print)					19b. Mailing Address (Street and Number or Rural									
and 2 Health em 2 ther t		M. A. O'Don:	ne11/I	Daughter			22 Wa1s Disposition (N		reet, Ch		_				_	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 X Burial 2 ☐ Crem	ation 3 🗆	Removal from Si	ate	Gate	of He	aven ^{lac}	ce)	Date		_ocation - (
mit. Partme		4 Donation 5 Other (Specify) Cemetery April 2, 2012 Silver Spring 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy													_	
Depar Impo any ir once		> John	I.Fr.	no	— MC	1360	Robert 7557 Wi	A. Pui	mphrey Fur in Avenue,	neral Home Bethesda	, Mar	nesda⊣(yland	hevy 20814	Chase, Inc3501		
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximat														
Physician/		Immediate Cause (Final disease or condition resulting in death)					neumon	ia						Onset and Death		
Medical Examiner		resulting in death)		·	as a conse):									
5551	ner	Sequentially list conditions, if any, leading to immediate	J	D	phagi as a conse):						-		_	
executed ian and urial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.														
e e		resulting in death) Last		Due to (or	as a conse	quence of):									
cate be physicia s the bu	dic		-	d									-		_	
Attending Physician: The law requires that the death certificate be or death. ector: After this certificate has been signed by the attending physici by the funeral director, page 2 should be detached for use as the bu	Physician/Medical	IF FEMALE: 23b. Was decedent pregnan		23c. If <u>ye</u> s, outco								23d. Date	of delive	in/		
eath c atter d for u	icial	in the past 12 months? 1 Live Birth 2 L Pregnant at tir									Month Day Year					
the dea by the a tached	hys	g □ Unknown 9 □ Unknown														
v requires that the sbeen signed by the should be detach	ρ	Part II. Other significant conditions contributing to death but not resulting in the underlying ca Prostate Cancer							ven in Part I.		use contribute to the cause of death?					
equire	eted	FIOS							1 Yes 2 No 3 Probably 4 Unknown							
sician: The law I certificate has t lirector, page 2 s	Completed										s an opsy formed?	Pi	ere autop ior to cor eath?	sy findings available npletion of cause of		
in: The ificate or, pa		25. Was case referred to me	dical					26 PI	ace of Death (Ch	1 ☐ Ye	2 X N	lo 1	☐ Yes	2 🗆 No	_	
ysicia is cert direct	To Be	examiner? 1 Yes 2 X No	☐ ER/Out	Other:					5 X Residence 6 □ Other (Specify)							
ng Phys fter this ineral di		27. Manner of Death 1 X Natural 5 - F	28a. Date of	28a. Date of injury 28b. Time of 28c. Injury at work?						28d. Describe how injury occurred						
tendii death. tor: A the fu	Certificate:	2 Accident Ir	vestigation could not be			М	1 🗆	Yes 2 ☐ No	1					_		
l or At after d Direc	Cert	4 ☐ Homicide d	Injury - At etc. (Spec							(Street and Number or Rural Route Number, own, State)						
To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funera	Medical													d.	-	
the Ho lin 24 the Fu	Med			ner: On the basis e Practitio ner: T										se(s) and manner state tated.	ed	
To t To t		29b. Signature and title of certifier 29c. License number 29d, D									Date signed (Month, Day, Year)					
Vlam		1 Wall				D70315					March 29, 2012					
30, 0		30. Name and address of pe						levar	d, Suite	#625, Ro	ckvi	11e, N	(ary	and 20852		
Stat	e	31 Date filed (Month Day Y	ear)	32 Reg	istrar's Sigr	natu	parks	1		,					-	
Registra	ır	APR	3 20	12 Law	we	P. 1	garre									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death 3. Time of Death March 30 2012 Physician/ 5:17 AM onia den Medical Facility Name (if not institution, give street and number Town, or Location of Death **Examiner** Burnu Boltimere Washington Medical Glen BUNG If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Hours **Director** 213-06-0897 1 🗆 M 2 🗓 F Yrs 43 1968 MARYLAND JUN. 8, Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10a. State Director 1 ☐ Yes 2 🕅 No MARYLAND ANNE ARUNDEL CO GLEN BURNIE 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? Funeral 6329 HARRIS HGTS AVENUE 21061 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. by 1 XX ever Married 2 Married filed within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XXNo Specify: Specify: BLACK "natural", Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) marked other than Elementary/Secondary (0-12) College (1-4 or 5+) other traumatic event, the BALTIMORE CO GOV. 12yrs 4vrs CASE MANAGEMENT Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ပ ETHEL CROMARTIE PERNELL B. ODEN, SR. and is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JC,

t. Page 1 and 2 s,

ent of Health and
titem 27 Angela R. Oden/Sister 101 Elizabeth Ave., Baltimore, Md., 21225 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Date Important: If it any injury or o once. cemetery, crematory or other place) 1XXBurial 2 Cremation 3 Removal from State REST CEMETERY 04 - 5 - 12GLEN BURNIE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundal Service Ucensee 22. Name and Address of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 206 W NORTH AVENUE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Cardiac arrhythmia Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner UNKAUWA AVAYA CLYOLIOMYO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner or Attending Physician: The law requires that the death certificate be executed by the attending physician and stached for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 month 1 Yes 2 No Day hths? Month Year 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by disease on dialysis 1 Yes 2 No 3 Probably 4 Unknown peen : 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform 1 Yes 2 No 2 No this certificate 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 No Other: 70 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Director: After (Month, Day, Year) work? 1 ☐ Yes 2 ☐ No 5 Pending injury Natural Investigation Accident filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital o within 24 hours aff To the Funeral Di Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Continue Practitioner To the best of my provided a continue of the cause of the ca Cartifying Nurse I ofcertifier 29d. Date signed (Month, Day, Year) 29b. Signature and 29c. License number Much 30, 2012 00022483 MY

Registrar
DHMH 17 Rev 06-2011

State

30. Name and address of person who o

31. Date filed (Month, Day, Year)

STUGUT JACOBE MO

305 Nocpital Dr. Glen Burnie, mp 2106

empleted cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last 2. Date of Death Physician/ Menth 256 Medical Facility Name (if not institution, give street and number) **Examiner** or Location of Death 4c. County of Death Tulsemere Road Baltimore Randállstown . Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) -72-6980 If Under 1 Year **Funeral** Hours Min Days 89 1 □ M 2 🔀 F Director 3-26-23 SC 10a. State at County 10c. City, Town or Location 10d. Inside City Limits Director notified MD 28a-f Baltimore Randallstown 1 Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? must be i Funeral 9710 Tulsemere Road 21133 USA items Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc ò þ 1 Never Married 2 Married ☐ Yes 2. XXVIo Baltimore, Maryland 21215-0036 1 and 2 should be filed within 72 hours after Black If Yes, Give Year or Dates 1 Yes 2XXNo Specify. "natural" Specify: Completed 3 XXVidowed 4 ☐ Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 0 Homemaker Own Home of Health and Mental Hygie If item 27 is marked other or other traumatic event, the Be 17. Father's Name (First, Middle, Last) Warren Butler 18. Mother's Name (First, Middle, Maiden Sumame) ည Carrie Loney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9710 Tulsemere Rd, Randallstown Maryland 21133 Janie Fulton / Daughter cof P : If it 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 K Removal from State Department o Important: If any Injury or Dalzell. SC 4 Donation 5 Other (Specify) Hopewell Baptist Cem. 3-7-2012 of Funeral Service Licensee Victor P. Doda Tes L. Stevens Funeral Home, Inc. E. Fort Avenue, Baltimore MD 21230 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exami the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Pregnant at time of death Month Day Year signed by the a 2 No 4 ☐ Pregnant 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 4 John Minknown 1 Yes 2 No 3 Probably page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law 24 hours after death. autopsy certificate has 1 Yes 2 No Yes filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: ည 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Pesidence 6 ☐ Other (Specify Director: After this 27. Manner of Detth 28c. Injury at work? 1 Yes 2 No 28d. Describe how injury occurred 28a. Date of injury 28b. Time of Certificate: Natural (Month, Day, Year) injury 5 Pending Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined Funeral Medical 29a. Certifier pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

within 2 To the I

State Registrar only one)

iled (Month, Day, Year,

n who completed cause of

(Item 23a) (Type,

3 Certifying Nurse Practitionar: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 201^{Ygar} April 11:45p M 1 Physician/ Prince L. Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner Sykesville Carrol1 Fairhaven If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Nov 22 1928 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number **Funeral** Months Days 83 MD 217-24-3900 1 □ M 2 □XF Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 28a-f show ral", or items 23a or 28a-f sho Examiner must be notified at 1 Yes 2 X No Sykesville MD Carroll 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number Funeral LISA 21784 C-099 7200 Third Ave. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Never Married 2 X Married 1 Yes 2 X No þ Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: white nan "natural", o Medical Exan Completed 3 Widowed 4 Divorced Year or Dates. 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. other than " College (1-4 or 5+) Elementary/Secondary (0-12) of the and Mental Hygiene.

27 is marked other than traumatic event, the M education teacher 6 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve any injury or other traumatic eve Elizabeth Hine ပ Henry Lummis Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cock 7200 Third Ave. C-099, Sykesville, MD 21784 19a. Informant's Name/Relationship (Type, Print) Mr. Robert Prince (spouse) Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Marriottsville, MD Crest Lawn Memorial 4-6-12 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityHaight Funeral Home & Chapel 21. Signature of Funeral Service Licensee P.O. Box 195 Sykesville, MD 21784 Paigrofaight 3 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ heimer disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Pregnant at time of death 5 Other (specify) 23d. Date of delivery 23b. Was decedent pregnant Month Day in the past 12 months? 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by hypothypoidism 1 Yes 2 No 3 Probably 4 Unknown ior: After this certificate has been si the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 ☐ Yes 2 ☐ No Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes မ 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 2 No 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certificate: 1 Natural 5 Pending Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours a To the Funeral Completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier only one) 29b. Signature and title April 2 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eldersburg MD 21784 1645 Jan MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2012 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Harry Edward **Phillips** 30. 2012 P^{M} March 6:30 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Hospice Casey House Rockville Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 081-32-7208 1 🛚 M 2 🗆 F Director 84 September 22, 1927 New York Usual Residence of Decede notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery Silver Spring 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be Funeral 3500 Forest Edge Drive, #3D 20906 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, the Medical Examiner was becedent Ever in 0.5.

Armed Forces?

1 K Yes 2 No 1945—
If Yes, Give Year or Dates. Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 X No Specify Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Naval Officer $5\pm$ Navy other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) P Harry Howell Phillips F. Powers Helen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 3500 Forest Edge Drive, #3D, Silver Spring, Maryland 20906 Aaslang R. Phillips /Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 1 Burial 2 K Cremation 3 Removal from State April 3, Montgomery Crematorium, Inc. Bethesda, Maryland 4 Donation 5 Other (Specify) 2012 Signature of Funeral Service Ligenses Robert A. Pumphrey Funeral Home/Rockville, Inc. Markettak M01305 Marke 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 23a. Part 1. Efter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph si ian Parkinson's Disease Years disease or condition Medical resulting in death) Due to (or as a consequence of Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or as a consequence of): Exami Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Pregnant at time of death Yes 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Nuknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of autopsy death? 1 ☐ Yes 2 🗓 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 XI No 1 Yes Hospice 1 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 2 Inpa 4 Nursing Home 5 Residence 6 X Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural

Examiner The law requires that the death certificate be executed burial-tra Division of Vital Records, P.O. Box 68760 the attending phy 88 nse ō been signed by the should be detach page 2 s has certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director, After this certifics completely filled in by the funeral director.

28a-f show with the Maryland

ò

items 23a

ō

"natural",

and Mental Hygiene.

je 1 and 2 should b t of Health and Mei

death

hours after

within 72

Baltimore, Maryland 21215-0036

Medical

29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bindu C. Joseph, MD

Accident

Suicide

4 Homicide

31. Date filed (Month

29a. Certifier (Check

5 Pending

Investigation 6 Could not be

3

6001 Muncaster Mill Road, Rockville, Maryland 20855 Registrar's Signat

injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

work? 1 ☐ Yes 2 ☐ No

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D0060634

3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

28f. Location (Street and Number or Rural Route Number,

29d. Date signed (Month. Dav. Year)

March 30, 2012

City or Town, State)

State

State of Maryland / Depa	artment of Health and Ment	al Hygiene			
Cer	tificate of Death	Reg. No.	2012	10	291
		ate of Death		3. Time of	
erson Pincock	Ma	Month Day	2012 Year	4.40	D M

rilysiciali
/Medical
Examiner

Funera Directo

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Physician /Medica Examine

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division or Vital Records, P.O. Box 68760,

12 State

		State Registrar			Cer	rtificate	e of L	Death			Reg. N	0. 2		2	$\perp 0$	290
	d	1. Decedent's Name (First, Middle, Last)								2. Date of De Month		ay	Voor	3.	Time of D	eath
ciar lica	-	Hazel Hende	rson Pin	cock						March	30,	2012	Year 2	4:	:40	Рм
ine	-	4a. Facility Name (If not institution, give str	eet and number)			4b. City,	Town, or	Location	of Death		4	c. County	of Deatl	h		
		Rockville Nursing	Home				Roc	kvi1	le			Mont	gome	erv		
1		Social Security Number 6. Sex	7. Age	(In yrs. last bir	thday)	If Under		If Under		8. Date of Bir	th Yes		9. Birth	hplace ((State or	Foreign
r		518-16-5844	/ 2 <u>\</u> F	90	Yrs.	Months	Days	Hours	Min.	(Month, Da Aug. 24	1	21		untry) Lrgi	nia	
	ı	Usual Residence of Decedent														
		10a. State 10b. County		10c. City, Tow	or Lo	cation								10d. in	nside City	Limits
1	2	Maryland Montgome	rv			ç	Silve	er Sp	ring					1	☐Yes 2	2 ∑ No
1	חובכוסו	10e. Street and Number				10f. Zip					10g. C	itizen of	What Co	untry?		-
15	=	10115 Meadowne	ck Court					2091	0			Unit	2 60	tate	A C	
	Lallera		. Was Decedent E	ver in U.S.	13. \	Was Dece	lent of Hi			ecify Yes or No Rican, etc.)		14. Rac	e - Amei	rican inc		
i.	2	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 📉 N	О						Rican, etc.)		Blac	ck, White	e, etc.		
i	2	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1 ☐ Yes	2LX No	Specify.	:			Specif	y: Wł	nite	:	
13	2	15. Decedent's Educa	tion	16a.	Dece	dent's Usua	al Occupa	ation			16b.	Kind of B	usiness/	Industry	/	
1 2	2	(Specify only highest grade of Elementary/Secondary (0-12)	College (1-4or 5	-\	(Give life. l	kind of woi DO NOT us	rk done d se retired	luring mos)	st of worki	ing						
	5	Elementary Secondary (6 12)	5+	''		Τe	ache	r				Ed	ucat	ion		
	pe combiered by	17. Father's Name (First, Middle, Last)						18. Moth	er's Name	a (First, Middle	, Maide	en Surnar	ne)			
	2	Herbert M	artin He	nderson	ı				(0sceola	. Fe	rgus	on			
	7	19a. Informant's Name/Relationship (Type				ng Address	(Street a	and Numb		al Route Numb				 Zip Code	e)	
		Dee Whitford Pinco	ck. Jr./	Son 10	111	5 Mead	ownec	k Com	rt. Si	ilver Spr	ino.	Marv	land	2091	10	
	Ť	20a. Method of Disposition	city of the	20b. Place of	Dispo	sition (Nan	ne of	i		Date		Location				
		1 ⊠ Burial 2 □ Cremation 3 □ Rer	moval from State	Fergu	ry, crer Son	Fami	iner piac Ly	e) [[Apri1 201	.14,	Roar	noke	Coun	t w	Viro	ginia
,	}	4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee		Ce		tery	d Addros	e of Eacil						•	_	-
		21. Signature of transfer diversity		0198	Ro	bert	A. P	umph	rey F	uneral	Hom	e/Ro	ckvi	11e	, Inc	C.
	1	23a, Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest.											, Mar		ind 20 proximate	
	Į	shock, or heart failure. List only one immediate Cause (Final	cause on each lin	e.					our dido (or respiratory t	arrest,			Inter	rval Betw set and De	/een
		disease or condition resulting in death)		gestive		art Fa	ailu:	re								
				consequence												
١,	_	Sequentially list conditions, b.		Lal Fibi		Latio	n									
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	,	•	,	D.		_								
	Xaii	that initiated events c. resulting in death) Last		onary An		гу рт:	sease	E	-							
				entia	J.,.											
	Medical	d.														
48	Me	IF FEMALE:	c. If yes, outcome	of programov												
	2	23b. Was decedent pregnant in the past 12 months?	1 ☐Live birth	2 Fetal death		Ectopic pr							ate of deli	livery Day	Y	ear
	by Physician	1 □ Yes 2 🖾 No 9 □ Unknown	4□Pregnant at 9□Unknown	time of death	5 L	Other (sp	еспу)									
i	=	Part il. Other significant conditions contr	ibuting to death bu	ut not resulting in	n the u	ndedvina c	ausa nive	an in Part		23e Did	tobacco	use con	tribute to	the ca	use of de	agth?
1	2	Take in the second second	ibading to dodd i be	remot resulting in	T trio u	naony ing o	adoc givi	on mir dit				2		robably		nknown
	5									, ,	163	2 140	3 11	Obably	442101	IKIOWII
	2									24a. Was	psy		prior to o	itopsy fi	findings a	vailable use of
	Completed									perf 1□ Yes	ormed?		death?	2 🗆	No	
	90	25. Was case referred to medical examiner?						26. Plac	e of Deat	h (Check only	one)					
	0	1 ☐ Yes 2 🔀 No Ho	spital: 1 □ Inpatie	nt 2□ER/Ou	ıtpatier	nt 3 DC	Othe	er: 4⊠N	ursing Ho	me 5 Res	idence	6 □Ot	ner (Spe	cify)		
		27. Manner of Death 11☑ Natural 5 ☐ Pending	28a. Date of Inju (Month, Day	y 28b.	Time o Injury	of 2	28c. Injun Worl	y at k?		28d. Describe	how in	jury occu	rred			
	ĭ	2 ☐ Accident investigation				М		Yes 2□]No							
		3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injubuilding, etc.	iry - At home, fa c. (Specify)	arm, str	reet, factory	y, office			28f. Location City or To	(Street own, Sta	and Num	ber or Ri	ural Rou	ute Numb	er,
1	Certification:															
1	Medical	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examine	cian: To the best or: On the basis of and manner sta	examination ar	e, deat nd/or in	th occurred ovestigation	at the tin	ne, date a pinion, de	ind place, eath occur	and due to the rred at the time	e cause e, date a	(s) and mand place	anner as , and due	s stated e to the	cause(s)	1
	Me	29b. Signature and title of certifier				290	c. License	e number		T	29d. [Date signe	ed (Mont	th, Dav.	Year)	
			1. Just	nh			D47					March			,	
		30. Name and address of person who corr		, ,	Type	Drint\										
		Thomas V. Joseph, M.		Wes t Ed			Driv	re #2	.07,	Rockvi1	Lle,	Mar	y1an	d 20	0852	

Registrar

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ AEI PS Month CAROLYN Day Year 225 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death GROMWELL BALTIMORE BALTIMORE NUBSING MOME | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Apr. | 28 | 6. Sex 9. Birthplace (State or Foreign 7. Age (In yrs, last birthday) Funeral 1 M 2 F Yrs. 1962 Marvland Director Apr. 216-80-5522 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f 1 Yes 2 No Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? must be n Funeral 8710 Emge Road 21234 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. ò þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural" Completed 3 Widowed 4 Divorced Specify. White Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the Travel Agent Travel Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental 27 is marked c traumatic eve ပ Elizabeth Martha Pickett John Downing Phelps 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a If item 27 is or other tra . 27 Phyllis Gilbert / Friend 10 Meadow Spring Dr., Bel Air, Maryland 21015 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Department of Important: If it any injury or o 1 Burial 2 Eremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hill 4-4-2012 Bel Air, Maryland Svcs, LLC 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ SEPTIC SITOCK disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** NEUMO WEEK Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): PARGI ng physician and as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last MULTIPLE Physician/Medical attending IF FEMALE: for use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death sate has been signed by the a page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 1 Yes 2 No Yes 25. Was case referred to medical funeral director. 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☐ No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury s after death. work? 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical

Division of Vital Records, P.O. Box 68760 Hospital or Attending Physician: 24 hours after death. completed filled in by

To the I within 2

State Registrar 29a. Certifier

(Check

only one)

ゆとしばれるの 31. Date filed (Month, Day, Year)

22200

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

82. Registrar's Signature

8710 EMGE

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

PARKVILLE mos

12

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month RITA DATTI 245 A M MARCH Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death HOPKINS HOSPITAL THE JOHNS BALTIMORE 17 6. Sex 7. Age (In yrs. last birthday) Date of Birth **Funeral** If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 214-22-9128 Country Director 1 □ M 2x F 91 03/21/1921 Usual Residence of Dece Maryland show at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director N/A notified Maryland Baltimore 28a-f 1 ¥ Yes 2 □ No 10e. Street and Number ò 10f. Zip Code item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be 10g. Citizen of What Country? Funeral 1020 Eastern Avenue 21202 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc. Page 1 and 2 should be filed within 72 hours after of ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or þ 1 K Never Married 2 Married Baltimore, Maryland 21215-0036 I ☐ Tes Z : If Yes, Give Year or Dates 1 ☐ Yes 2 H No Specify White 3 Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done duning most of working life. DO NOT use retired) id Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Cook Restaurant Business Be Father's Name (First, Middle, Last)
Louis Patti 18. Mother's Name (First, Middle, Maiden Surname) Mary Bruno ျှ 19a Informant's Name/Relationship (Type, Print) Mr. John G. Orendorff – Nephew 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1244 Francis Avenue Baltimore, MD 21227 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or o 1 K Burial 2 Cremation 3 Removal from State Most Holy Redeemer Cemetery 04-03-2012 Baltimore, MD 4 Donation 5 Other (Specify) Funeral Service Licensee 22. Name and Address of Facility 5305 Harford Road Leonard J. Ruck, Inc. Baltimore, Maryland 21214 23a. Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a or ni equence of) **Examiner** Esquentially fist conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) certificate be executed burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Box 68760 as the attending p IF FEMALE res, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy 5 Other (specify) Month Pregnant at time of death Day Year ed by the a 9 Unknown Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of has autopsy performed? certificate | death? Yes 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital မ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manger of Death 28b. Time of After t Certificate: 28c. Injury at Natural 5 Pending work? Director: And in by the f Accident Investigation 2 No Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours aft

To the Funeral Di

completely filled in Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Praction ner To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner are stated. (Check 29b. Signature and title of contifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000 MARCH 30, 2012

State Registrar 600 N NOLFEST. BALTIMORE MD 21287

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar Signa

>000il

31. Date filed (Month, Day,

APR 03

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2012 Wanda K. Pacheco 4:38P 28 March 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Oakland Manor Assisted Living Sykesville Carroll Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) (Month, Day, Months Hours 026-07-1801 99 1 □ M 2 🛛 F 7 Aug 1912 Mass 10b. County 10c. City, Town or Location 10d. Inside City Limits Carroll Sykesville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2012 Rudy Serrah Dr. Unit C 21784 USA Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married 1 Yes If Yes, Give 1 Yes 2 No Specify: Specify: White 3 X Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Textile Mill Weaver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Adam Karus Apolonia Mazur 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Kozlowski-daughter 2012 Rudy Serrah Dr. Unit C, Sykesville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Evergreen Memorial 3/31/12 Finksburg, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Fletcher Funeral Home Ε. Main St., Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final AnnonisceConi Wiovalla Car Dilean Onset and Death

Physician/ Medical Examiner

Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Me

Physician/

Medical

10a. State

Examiner

Funeral

Director

3a or 28a-f show t be notified at

must be

"natural", or iten edical Examiner r

Director

Funeral

þ

Completed

Be

မ

Page 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Physician/Medical Examine burial-transi and attending physician as the nse for be detached þ To Be Completed by should peen has this Certificate: within 24 hours after death. To the Funeral Director, After filled in by the

Medical

3 Suicide
4 Homicide

only one 29b. Signature

31. Date filed (Month, Day, Year)

29a. Certifier

6 Could not be

3 2012

and title of cert

determined

30. Name and address of person who completed cause of death (Item 23a) (Type

The law requires that the death certificate be

or Attending Physician:

the Hospital

Division of Vital Records, P.O. Box 68760

resulting in death)	a. Due to (or as a consequence of):	(21) 010
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. — Due to (or as a consequence or).	
resulting in death) Last	Due to (or as a consequence of): d	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 → No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)	23d. Date of delivery Month Day Year
Part II. Other significant conditions	s contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ûnknown
		24a. Was an autopsy performed? 1 \[\sum \text{Ves} \ 2 \sum \text{No} \] 24b. Were autopsy findings available prior to completion of cause of death? 1 \[\sum \text{Ves} \ 2 \sum \text{No} \] 1 \[\sum \text{Ves} \ 2 \sum \text{No} \]
25. Was case referred to medical examiner? 1 Yes 2 No	26. Place of Death (Check or Hospital: Other: Other:	
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigat	28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at work? 28c. Injury at work?	5 Residence 6 Ather (Specify) ASH LIND

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Means Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d, Date signed (Month, Day, Year

MD 2115

DHMH 17 Rev 06-2011

State

Registrar

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 201^{Yea} 29 March 3:25 Elizabeth Florence Pohlhaus Medical 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Renaissance Gardens At Riderwood Prince Silver Spring Georges Age (In yrs. 90 Birthpia Country) NJ 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 3/28/1922 Months 1 □ M 2 🔀 F Days Hours Min. Director 143-16-3022 Usual Residence of Decedent 23a or 28a-f show 10a. State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No MD Prince Georges Silver Spring 큡 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 3160 Gracefield Road 20904 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give filed within 72 hours after Maryland 21215-0036 Specify: White 1 Yes 2 No Specify: 3 X Widowed 4 ☐ Divorced "natural", Year or Dates other traumatic event, the Medical 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Merian injury or other traumatic event, the Merians injury or other traumatic event. Chemist Private Industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Edward Ryan Nellie Agnes Mulhern 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 548 Mowbray Arch, Norfolk, VA 23507 Mari Pohlhaus/Daughter Baltimore, 20a Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Howard Univ. Med. School 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 C Other (Specify) 3/29/2012 Washington, D. C. Signature of level eral 22. Name and Address of FacilitAustin Royster Funeral Home 10 3821 14th Street NW, Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate
Interval Between
Onset and Death
I year shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Vascular Dementia disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Unknown <u>Hyperlipidemia</u> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of Exami that the death certificate be executed Unknown Hypertension attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 XNo Month Pregnant at time of death ed by the a 9 Unknown 9 Unknown P.O. signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? [조 Division of Vital Records, Hospital or Attending Physician: The law requires Atrial Fibrillation cate has been sig page 2 should b 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform within 24 hours after death.

To the Funeral Director: After this certificate completed filled in by the funeral director, pag 1 Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo 은 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🛛 Natural 5 Pending 1 Tes 2 🗌 No 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State Registrar 29b. Signature and title of certif

31. Date filed (Month, Day, Year)

<u>Gemmel</u>

APR 0 3 2012

30. Name and address of

Eileen

DHMH 17 Rev 7/2009

3160 Gracefield Road, Silver Spring,

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

CRNP

29d. Date signed (Month, Day, Year)

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ March 31Edward Price Roberts, Jr. 2012 11:32 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Catonsville 31 Bryans Mill Way Birthplace (State or Foreign Country) Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) **Funeral** Days 170-26-5861 Director 1 X M 2 🗆 F 76 March 3,1936 Washington DC show 10d. Inside City Limits 10c. City, Town or Location must be notified at Director 28a-f s Catonsville 1 Yes 2 No Baltimore Marvland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö Funeral 23a 21228 United States 31 Bryans Mill Way ral", or items? Examiner mus 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 X Married permit. Page 1 and 2 should be filed within 72 hours after Yes, Give 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White 3 Widowed 4 Divorced Year or Dates and Mental Hygiene.

Is marked other than "natur:
raumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-,4 or 5+) Hardware Sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ano cof Health and them 27 is mark. ပ Marjorie Ann Phillips Edward Price Roberts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 31 Bryans Mill Way, Catonsville, Maryland 21228 Elizabeth Roberts/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1
Burial 2
Cremation 3
Removal from State Metro Crematory Inc 04/03/2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee George E. MacNab 22. Name and Address of Facility Cremation Society of Maryland Inc 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line OBSTRUCTIVE LUMB DISRASE HRONIC Immediate Cause (Final DVEARS Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions. Examine Due to for as a consequence of if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-tra Due to (or as a consequence of) physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? ō Month Day Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No page 2 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{X} \) Residence \(6 \text{ \text{Other} (Specify)} \) 1 Yes 2 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Matural 5 Pending work after death. 1 🗌 Yes 2 🗐 No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical Modertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier within 24 hor To the Fune completely fi (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 29d. Date signed (Month, Day, Year) APRIL 3, death (Item 23a) (Type, Print) 2465 Route 97 GLENWOOD IND SUITE 10 State APR 03 Registrar

DHMH 17 Rev 06-2011

				/pe or Print in B ANA BD G926 State of Maryland				I Copies a&b lental Hyg	Are Legi piene 2	ble. 0 2	10296
			1 - State Registrar		Cer	tificate of	Death	R	eg. No.		
			1. Decedent's Name (First, Middle, Last)	<u> </u>	2			2. Date of Dea			3. Time of Death
% .	Physici		Elizabe Un	Kutledi	38			Month 3	Day 14	Year	10:15 PM
-	/Medic		4a. Facility Name (If not institution, give st	reet and number)	1	4b. City, Town, o	r Location of Death		4c. County	of Death	
CAN-	Examin	iei		75 ROCKIPASE	AVP.	Backil	VA CRO		Ball	timan	e .
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. Ia	st birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth)		e (State or Foreign
М	Director		214205473 10	M 20 F 90	Yrs.	Months Days	Hours Min.	(Month, Day	(, Year)	Country)	Carolina
			Usual Residence of Decedent								
	ylan yow at		10a. State 10b. County	10c. City	Town or Lo	cation				10d.	Inside City Limits
	Mar Fied	ior	MD	Ва	1timor	re e					1 Yes 2 □ No
	1 28.	Director	10e. Street and Number			10f. Zip Code		1	10g. Citizen of	What Country	?
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	밑	3001 Pelham Ave.			21213			USA		
	ms 2	Funeral	11. Marital Status unk	2. Was Decedent Ever in U.S	3. 13.	Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	14. Rac	e - American	
(0	r ite		1 ☐ Never Married 2 ☐ Married	Armed Forces? unk 1 ☐ Yes 2 ☐ No				Hican, etc.)		ck, White, etc	
ဗ္ဗ	al", o	by	3X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 □ Yes 2 □XNo	Specify:		Specif	y: Black	
21215-0036	2 ho	Completed	15. Decedent's Educ		16a. Deced	ient's Usual Occup	oation unit	da a	16b. Kind of B	usiness/Indus	try un k
7	in 7	ble	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	DO NOT use retire	during most of work d)	ing			
2	d with	E	12 unk- 0	-unk	House!	keeping			Hospi	itality	7
g	othe vent,	Be	17. Father's Name (First, Middle, Last) 1	ınk			18. Mother's Name	e (First, Middle,	Maiden Surnar	^{ne)} unk	
Maryland	2 should be filed and Mental Hygi is marked other aumatic event, it	To E									
a	shol Nand Nand Nand Nand Nand Nand Nand Nand	-	19a. Informant's Name/Relationship (Typ		19b. Mailir	g Address (Street	and Number or Built	al Poute Numbe	n ^{Cit} A& Ime	State, Zip Co	ode)
	1 and 2 Health a tem 27 is		Artie Shaw – gua	ardian			imore St				
=	oth		20a. Method of Disposition		ace of Dispo	sition (Name of natory or other pla		Date	20c. Location		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the Medical Examiner must be notified at once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 🛛 Other (Specify)	emoval from State		,	, t				
=	mit.		21. Sign ware of Funeral Service Liver	111	22	2. Name and Addre	ess of Facility Šta	ate Anat	omy Boa	ard	
m	Depa Impo any I		Smill !!	de Director	- 10	655 W. I	Baltimore	St; Bal	timore,	MD 21	201
П			23a. Part 1 Enter the disease, or complice shock or heart failure. List only on	cations that caused the death	. Do not ent	er the mode of dyi	ng, such as cardiac	or respiratory ar	rest,	In	pproximate Iterval Between
-	Physician		Immediate Charles (Final disease or contilion	N+RO1-	500	Parat	r Card	1000	Cide	Delo	nset and Death
χď	/Medical		resulting in death)	Die to (or is a consequ	ence of):	Prov	card	- \		7 (20	
	Examiner			Advan	100	1 De	men	V-8			
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due o (or as a consequ	ence of):						
	executed in and ial-transit	Examiner	Cause, Enter Underlying Cause (Disease or injury that initiated events								
o,	e executed ian and ırial-transit	Exa	resulting in death) Last	Due to (or as a consequ	ence of):						
ဖ	Q 0 Q	ca	U d								
9289	ificat g phy as th	edi							1		
Вох	nding use	N	IF FEMALE: 23b. Was decedent pregnant 23	3c. If yes, outcome pf pregna		7			23d. Da	ate of delivery	
m	death atte	cia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 2□Fetal 4□Pregnant at time of de		∃Ectopic pregnand ∃ Other <i>(specify)</i> _	;y 		М	onth Da	ay Year
P.0	The law requires that the death certificate be ate has been signed by the attending physici age 2 should be detached for use as the bu	Physician/Medica	9 □ Unknown	9□Unknown							
п. П	w requires that been signed to should be deta	by P	Part II. Other significant conditions con	tributing to death but not resu	Iting in the u	nderlying cause gi	ven in Part I.	23e. Did to	obacco use cor	tribute to the	cause of death?
Records,	quire; n sig	d b						1 🗆 1	∕es 2□ No	3 ☐ Probab	ly Dunknown
00	w rec	Completed						24a. Was	an 24b.	Were autops	y findings available
Be.	The lav	E		· · · · · · · · · · · · · · · · · · ·				autop perfo	rmed?	prior to comp death?	letion of cause of
ā			25. Was case referred medical				00 81 (8	1□ Yes	2 No	1∐Yes 2	ZNo
Vital	Physiclan: r this certifica ral director, p	Be	examiner?	ospital:	ED/Out-still	nt 3 DOA Ot	26. Place of Dea				
O	Phy:	-L	27. Manner Death	1 ☐ Inpatient 2 ☐ 28a. Date of Injury	28b. Time o			ome 5 Residence 1			
5	Attending r death. ector: After by the funer	io	Natural 5 ☐ Pending	(Month, Day Year)	Injury	Wo	ork?]Yes 2 □ No		,,		
2	deatl ctor: / the	ica	3 Suicide 6 Could not be	28e. Place of injury - At ho	me, farm, st			28f. Location (S	Street and Num	ber or Rural F	Route Number.
Division or	affer Dire	Certification:	4 Homicide determined	building, etc. (Specif)				City or Tov			,
_	Hospital 24 hours a Funeral I rely filled		29a. Certifier Certifying Phys	ician: To the best of my kno	wledge, deat	h occurred at the t	time, date and place	, and due to the	cause(s) and n	nanner as stat	ed.
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled ir by the funeral	Medical		ner: On the basis of examina and manner stated.							
	To the within 2 To the complet	₹ Z	29b. Signature and title of certifier	0		29c. Licen	se number		29d. Date sign	ed (Month, Da	ay, Year)
	- S - O		1 legold	\times M .	D.	NU	740	5	3/2	4/12	
			30. Name and address of person who co	moleted cause of death (Item	23a) (Tuno	Print)	-1000	/	1	1.1.	
			LIARA TA	61821-	NA	iou st	- Ball	Time	MI	2/2	01
2	St	ate	31. Date filed (Month, Day, Year)	2. Registrar's Signa	ture-		*	•			!
	Regist		APR 0 3 2012	Mention A	ba	Rad					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		_ For	State of Marylar	nd / Depa	artment of I	Health a	nd Men	tal Hygi	ene		1 0	007
	_	State Registrar		Cer	tificate of l	Death		Re	eg. No. 2 (112	10	291
Physicia	n/	1. Decedent's Name (First, Middle, Las	,					Date of Death Month	Dav	Year	3. Time of	Death
Medic	al	Earl Linwood Ro			4b. City, Town, c	r Location of		arch	26 2 4c. Count	.012	9:46	A IVI
Examin	er	2018 N. Calvert	· ·		Balti		Death		4c. Count	y or Death		
Funeral		Social Security Number 6. S		last birthday)	If Under 1 Year Months Days	If Under 24 Hours		Date of Birth	Vearl	9. Birthp Count	lace (State o	r Foreign
Director			X _{M 2 □ F} 59	Yrs.	Workins Days	Tiours		b 10,			vland	
tnd show at	or	Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ity, Town or Lo	cation		I e	D_10,	1933		Od. Inside Ci	ty Limits
Maryla 18a-f tified	rect	MD	F	Baltimo	re						1 🔀 Yes	2 🗆 No
with the I	Funeral Director	10e. Street and Number 2018 N. Calver	t St; 3rd floo	or	10f. Zip Code 21218	3		10	0g. Citizen of USA	What Coun	try?	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. Was Decedent Ever in U Armed Forces 1 Yes 2 No If Yes, Give Year or Dates.		Was Decedent of Hif Yes, specify Cuba	an, Mexican, I				ce - America ck, White, e	etc.	
n 72 hours an "natur Medical E	Completed	15. Decedent's Elementary/Secondary (0-12)	Education	(Give	dent's Usual Occup kind of work done O NOT use retired)	during most o	of working		16b. Kind of E	Business/Inc	lustry	
withir giene ner th t, the		unk	unk	la 1a	borer				mair	ntenar	ice	
d be filed Jental Hy arked oth	To Be	17. Father's Name (First, Middle, Last) Earl Linwood Ro	bbins Sr.						aiden Surnam Laurie	*		
12 should alth and Path and Pa		19a. Informant's Name/Relationship (7			ng Address (Street 02 Harts						iode)	
age 1 and ent of Hea nt: If item y or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ※ Other (Speci	Removal from State	Place of Dispo cemetery, crer	osition (Name of matory or other pla	ce)	Date	2	20c. Location	- City or To	wn, State	
permit. F Departm Importal any injul once.			Wade Directo	2r 22	2. Name and Addre				-		21201	
	-	23a. Pari 1. Enter the disease, or com shock, or heart failure. List only of	iplications that caused the dea	ath. Do not ente							Approximate Interval Bets	
Physician/ Medical		Immediate Oruse (Final disease or condition resulting in death)	a brabet	ic c	ompl	Ecut	ton	5			Onset and I	
Examiner	J.	Sequentially list conditions,	b. Drabe	fes								
ransit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consect.		nsion	1						
be executed sician and e burial-transit	dical E	resulting in death) Last	Due to (or as a consect	quence of):								
ificate ng phy as th	Med	IF FEMALE:										
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-trans.	Completed by Physician/Mee	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregn 1 ☐ Live Birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3	Ectopic pregnan Other (specify)	су				ate of delive onth	-	Year
requires that the der been signed by the s should be detached	d by Ph	Part II. Other significant conditions of Cebebyo Va				iven in Part I.		23e. Did toba	acco use con		e cause of d	
requi been shoule	lete	- Cepcell of a	200-07-2		w =		_	24a. Was an		Were autop	sy findings a	available
Physician: The law Ir this certificate has beral director, page 2 s	Comp							autopsy perform 1 🗆 Yes 2	ned? No	prior to cor death? 1 \square Yes	npletion of c	ause of
ician: Sertific ector,	Be	25. Was case referred to medical examiner?	Hospital:		26. P	lace of Death	(Check only	one)				
Physic this ceral dir	: To	1 Yes 2 No 27. Manner of Death	1 Inpatient 2 28a. Date of injury	ER/Outpatier	nt 3 🗆 DOA	4 🗀 Nurs	sing Home		nce 6 Oth			
nding Phyath. r: After thi	icate	1 Natural 5 ☐ Pending 2 ☐ AccidentInvestigatio	(Month, Day, Year)	injury	wor			200011301104	, injury social	.00		
To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	l Certificate:	3 Suicide 6 Could not be 4 Homicide determined			eet, factory, office			Location (Stre City or Town,	eet and Numb State)	per or Rural	Route Numb	er,
ne Hospit n 24 hour ne Funera	Medical	(Check 2 Medical Exam	rsician: To the best of my know inner: On the basis of examination are Practitioner: To the best of	on and/or inves	tigation, in my opini	on, death occi	curred at the t	ime, date and	d place, and du	ue to the cau	ise(s) and ma	nner stated.
To the comp		29b. Signature and title of certifier			29c. Licens				d. Date signe	ed (Month, E	Day, Year)	
		6./20	2 MD		DOC	537	265		3/2	7/20	12	
		30. Name and address of person who	completed cause of death (Item	m 23a) (Type, F	West Ro	Acres	20 5	F B	3/2;	reve	mr	
Stat Registra		31. Date filed (Month, Day, Year) APR 0 3 2012	62. Registrar's Signa	ature bar	les .				•	7		

DHMH 17 Rev 06-2011

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ :04A M einhar Much 31 Medical me (If not institutible **Examiner** or Location of Death 4c. County of Death **Funeral** Age (9. Birthplace (State or Foreign Day, Year) Hours Country Director 215-58-0634 1 □ M 2 😿 F 62 March 28,1950 Chelsea, MA 28a-f shov 10h County 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified Baltimore Rosedale Maryland 1 Yes 2XXVo 5 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a 21237 5404 Litany Lane United States 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. o þ 1 Never Married 2 Married 1 ☐ Yes 2 XXXVo 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2XXNo Specify White "natural" 3 🗌 Widowed 4 🗌 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental is marked o မှ Betty Rose Ball William Frederick Kraft, Sr. 19a. Informant's Name/Relationship (Type, Print) Department of Health an Important: If item 27 is naw jujury or offer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Raymond Reinhardt (Spouse) 5404 Litany Lane Rosedale, Maryland 21237 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1XXBurial 2 Cremation 3 Removal from State April 04,2012 Rosedale, Maryland Cardens of Faith Cemetery 4 Donation 5 Other (Specify) Name and Address of Facility
Evans Funeral Chapel & Cremation Services-Parkville
Many land 21234 Signature of Funeral Service License 8800 Harford Road Parkville, Maryland 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) ardio pulmonary Medical Due to (or as a consequence of Examiner tumor Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed High Grade and burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 Who 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Pregnant at time of death Day Year be detached 9 Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 X Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate has autopsy 2 X No 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?

1 Yes 2 No Hospital မှ 1

Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this funeral (27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🗷 Natural 5 Pending iniury work? 1 Yes 2 No Accident Investigation after death filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State, within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

10 dr.

Registrar

DHMH 17 Rev 06-2011

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

THOMAS KOSZ TOWSKI, M.D. (600) N

THOMAS

31. Date filed (Month, Day,

APR 0 3 2012

March 31,2012

			For State		State of M	arylan		artmen <i>tificate</i>			and IV	ilentai Hy	_		1 6	1027)
			Registrar 1. Decedent's Name	e (First, Middle, La	ast)			lineate	- 01 L	catti		2. Date of De	Reg. N ath	10.		3. Time of Death	_
	Physicia Medic		Joseph		Н.		Re	eguls	ki			March	28,	2012	Year	10:20 P	Л
4	Examin				e street and number)		-			Location	of Death		4	c. County			
			Stella Ma 5. Social Security N						wson		04 11			Balt			
	Funeral Director		220–34–73 Usual Residence of	373	1 X M 2 □ F	ne (in yrs. ia 72	ast birthday) Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Bir (Month, Da June 1	v. Year	1939	9. Birthp Count Mary	lace (State or Foreig ry) Yland	n
	land show d at	tor	10a. State	10b. County		10c. Cit	y, Town or Loc	cation							1	0d. Inside City Limits	š
	Mary 28a-f otifie	Director	Maryland	Baltir	nore		Dun	dalk								1 🗆 Yes 2 і XN	0
	s 23a or	Funeral D	7795 Peni		xpressway	Apt	105	10f. Zip		2122	2		10g. 0	USA	hat Coun	try?	
р.ш. -0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status1 Never Marri3 Widowed	ied 2 □ Married 4 □ X Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.	Ever in U.S	- 1	Vas Decede Yes, speci				cify Yes or No- Rican, etc.)			- America K, White, e Whit	tc.	
0:20 p.m. 21215-0036	iin 72 hou ie. han "natu e Medical	Completed	(Spe	15. Decedent's cify only highest gondary (0-12)	Education grade completed) College (1-4 or	5+)		ent's Usual aind of work NOT use	done de	ation uring mos	t of worki	ng	16b.	Kind of Bus	siness/Inc	lustry	
10:	d with tygier ther t nt, th	Be C	12 years				Meat	Pack	er						skay		_
2012 1 Maryland	be file	To B	17. Father's Name (I									e (First, Middle, ymanick		n Surname)			
2012 Aaryla	nd Me		19a. Informant's Na		Type, Print)		19b Mailin	a Address			-	l Route Numbe		or Town St	ate Zin C	ode)	=
_	d 2 shealth a		Tobi M. I	Price	daughter							Baltim					
IARCH 28, Baltimore,	Page 1 an ment of He ant: If iten ury or oth		20a. Method of Disp 1 Denial 2 4 Donation		Removal from State	. С	lace of Disposemetery, crem	natory or oti	her place	e)	Mar ^t	計 31, 12	!	Location - C		wn, State aryland	
MARCH Baltin	permit. Departr Import any inji		21. Signature of Fur	neral Service Licer	Conne	lle	V 7	onneî 110 S	TyrF oll∈	uner ers P		ome Of Road,	Dun Dun	dalk, dalk,	P.A. MD.	21222	
			23a. Part 1. Enter the shock, or hear	he disease, or cor t failure. Aist/only	nplications that cause one cause on each lin	d the death										Approximate Interval Between	
1	Physician/		Immediate Cause (I disease or conditio	Final	LUNG											Onset and Death	
1	Medical Examiner		resulting in death)	•	Due to (or as	a consequ	ence of):									-	
		ner	Sequentially list con if any, leading to im	mediate	b. Due to (or as	a consequ	ence of):								-		_
	uted Id ransit	ami	cause. Enter Under Cause (Disease or that initiated events	пригу	C												
	cate be executed physician and s the burial-transit	edical Examiner	resulting in death) L	Last	Due to (or as	a consequ	ence of):										
09/	physics the b	edic			d										-		_
LSKI Box 68'	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a		IF FEMALE: 23b. Was decedent in the past 12 r 1 Yes 2 0 9 Unknown	nonths?	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Feta	Ideath 3	Ectopic pi Other (spe		/				23d. Date Mon		ry Day Year	
REGULSKI s, P.O. Box	ires that th signed by Id be detac	d by Ph	Part II. Other signifi	icant conditions	contributing to death b	out not res	ulting in the ur	nderlying ca	ause give	en in Part I	l.			use contrib		e cause of death?	n
JOSEPH R Division of Vital Records,	e law requ has been ge 2 shou	mplete										24a. Was autop		pr	ere autoprior to con	sy findings available apletion of cause of	
JO	an: The ifficate tor, pa	Be Co	25. Was case referre	ed to medical	T				26 Pla	ce of Deat	th (Check	1 🗌 Yes			☐ Yes	2 🗌 No	_
Vita	nysicia lis cert direct	To B	examiner? 1 Yes 2	(No	Hospital:	ent 2 🗆	ER/Outpatien	t 3 🗆 ĐO	Other	γ.			dence	6 👿 Other	(Specify)	HOSPICE	П
on of	ath. r: After th	Certificate:	27. Manner of Death 1 X Natural 2 Accident	5 Pending Investigation		ry y, Year)	28b. Time of injury	28 M	c. Injury work? 1 🔲 Y	at	2	28d. Describe h					
Divisi	tal or Atter rs after de al Directo		3 Suicide 4 Homicide	6 U Could not determined				et, factory,	office		1	28f. Location (S City or Tow			or Rural I	Route Number,	
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	only one) 3	Medical Exan	ysician: To the best of niner: On the basis of e rse Practitioner: To th	xamination	and/or investi	gation, in m	y opinior	n, death oc	curred at	the time, date a	nd plac	e, and due t	to the caus	se(s) and manner stat	ed.
	7 7 10 OO		29b. Signature and t	DW	Un	DN	PINP		License	number 30	272	2	29d. D	ate signed and all all all all all all all all all al	(Month, D	ay, Year) 2012	
	2x 81	1	TRACIE I	. MORGAN	completed cause of d	300 D	ULANEY		EY R	D. '	TIMOI	NIUM, M	D 2	7 1093	•		
	Stat Registra	e ır	31. Date filed (Month	3 2012	32. Registra	s Signa	arke										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #10e Per Harving / 4/05/2012 JH ealth and Mental Hygiene

		•	1 - State Of Maryland		tificate of L			Reg. No. 2	012	10300
	Physicia		1. Decedent's Name (First, Middle, Last) Timothy Scott Reuwer				2. Date of De	ath 30,20) Y=2	3. Time of Death 3:40A
ر	Medic Examin		4a. Facility Name (if not institution, give street and number) SAINT JOSEPH MEDICAL CENTER	R	4b. City, Town, or	Location of Deat	h	4c. County	of Death	₽E
_	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last		If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		th		place (State or Foreign
	Director		218-68-5759 Usual Residence of Decedent 1 ☑ M 2 ☐ F 59	Yrs.	Month's Days	Tiodia Ivini.		9, 1952		ryland
	yland -f shov ed at	ctor		Town or Loca					1	0d. Inside City Limits
	the Ma or 28a e notifi	Director	10e. Street and Number	lockey	sville 10f. Zip Code			10g. Citizen of	What Coun	1 ☐ Yes 2 🌠 No
	h with h	Funeral	12212 12272 Happy Hollow Road		210				SA	
21215-0036	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	þ	11. Marital Status 1 □ Never Married 2 ▼ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ▼ No If Yes, Give Year or Dates.		/as Decedent of H Yes, specify Cuba ☐ Yes 2 X No		pecify Yes or No- to Rican, etc.)	14. Rad Blad Specify	e - Americ ck, White, e : Whi	etc.
215-(72 hou an "nat Medica	Completed	(Specify only highest grade completed)	(Give ki	ent's Usual Occup ind of work done of NOT use retired)	during most of wo	rking	16b. Kind of B	usiness/Ind	dustry
1212	d withir lygiene ther tha	ø		Artis				Plant		ery
Maryland	be filed lental Hy rked oth ic event	To B	17. Father's Name (First, Middle, Last) Charles Reuwer			18. Mother's Na	me (First, Middle, Hurloc		e)	
dary	should n and Me ris mar		11	19b. Mailing	g Address (Street	and Number or Ru	ıral Route Numbe	er, City or Town, S	State, Zip C	(ode)
re, N	and 2 Health tem 27		R. Page Bloodgood/Wife 20a. Method of Disposition 20b. Plac	ce of Dispos	2 Happy	-		20c. Location	-	
Baltimore,	permit. Page 1 a Department of H Important: If ite any injury or ot		1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Memo	netery, cremo ney Va prial	atory or other place alley Gardens	e) Apri 20	.1 ^{Date} 3,		nium,	
Ball	permit Depart Impor any in		21. Signature Time Spring Deensee Michael J. Flagle		Name and Address mmon Fun W. Pado		e of Dul	Laney Va	11ey	Inc.
	Physician/ Medical		23a. Port 1 Finer the disease, or complications that caused the death. District, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a. DIFFUSE LAR	Do not enter	the mode of dyin	g, such as cardiad	or respiratory an			Approximate Interval Between
	Examiner		RESPIRATORY		LURE				2	DAYS
	ed nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ice oij.						
	cate be executed physician and s the burial-transit	Еха	that initiated events resulting in death) Last C. Due to (or as a consequence)	nce of):					\neg	
200	cate be physici s the bu	ledical	d							
30x 68	death certifi e attending ed for use a	≥	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No g ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deat g ☐ Unknown	death 3 🔲	Ectopic pregnand Other (specify)	ey .			ite of delive	ery Day Year
ds, P.0	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detach	by	Part II. Other significant conditions contributing to death but not resulting	ing in the un	nderlying cause giv	en in Part I.				ne cause of death?
Reco	n: The law re ficate has bo or, page 2 sh	• Completed	25. Was case referred to medical		oc pi	age of Death (Cha	1 Yes	osy ormed?		osy findings available mpletion of cause of
Vita	nysicial nis certi	To Be	examiner? 1 Yes 2 X No Hospital: 1 Xnpatient 2 ER	₹/Outpatient	Lou	ace of Death (Che er: 4 Nursing F	Home 5 Resid	dence 6 🗆 Oth	er (Specify))
ion of	tending Phath. tor: After the		1X Natural 5 ☐ Pending (Month, Day, Year) 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	8b. Time of injury	1111			now injury occurr		
Divis	al or At s after o		4 Homicide determined 28e. Place of Injury - At home building, etc. (Specify)	a, farm, stree	et, factory, office		28f. Location (S City or Tow	Street and Numb vn, State)	er or Rural	Route Number,
	the Hospit hin 24 hour the Funera npletely fill,	Medical	29a. Certifier (Check 2 Medical Examiner: On the best of my knowledge only one) 3 Certifying Nurse Practitioner: To the best of my knowledge only one)	nd/or investig	gation, in my opinio	n, death occurred	at the time, date a	and place, and du	e to the cau	use(s) and manner stated.
	라 샤		29b. Signature and title of certifier Luke adle M		29c. License	SY 7-U		29d. Date signe 3 - 30		
			30. Name and address of person who completed cause of death (Item 23		int)					
	Stat	e	LINDA ADLER, M.D. 760 31. Date filed (Month, Day, Year) 32. Registrar's Signature)1 OS	LER DRI	VE TOWS	SON, MD	21204		
	Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signature	Barke	Z .					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 28^{Day} 20°1°2 4:45 A^M David Wayne Smith Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Prince Georges Clinton Nursing, LLC Clinton Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Min Sept 23 ^{Year} 1947 1 X M 2 1 Director 64 Maryland 219-46-9131 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Glenarden 1 🗆 Yes 2 🔀 No Prince Georges 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20706 Funeral USA 3202 Hayes St. within 72 hours after death with 12. Was Decedent Ever in U.S. Armed Forces? 1 2 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 😾 No Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) maintenance laborer should be filed with and Mental Hygien 7 is marked other th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ೭ permit, Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Jerry Smith Margaret Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Floute Number, City or Town, State, Zip Code) 8702 Dorian Lane; Clinton, MD 20735 Nichol Fowler - daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 😾 Other (Specify) in state num of Euneral Service Licer Ronal I 22. Name and Address of Facility State Anatomy Board Baltimore St; Baltimore, MD 21201 Enter the disease, or demplications that crused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest or heart failure. List only one cause on payn line. Approximate Interval Between s t and De Immediate Cause (Final) Physician/ disease or condition resulting in death) Drue Medical (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due To the Hospital or Attending Physician: The law requires that the death certificate be executed tran and that initiated events Due to (or as a consequence of) resulting in death) Last physician a the burial-Physician/Medical Box 68760 as 1 IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Pregnant at time of death signed by the 9 Unknown 9 I Inknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Was a autopsy performed? within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 s 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 1 🗌 Yes 2 100 Other: ည 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending М 1 🗆 Yes 2 🗀 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 29b. Signatur

DAVIS 31. Date filed (Month, Day, Year) AVIATION

s of person who completed cause of death (Item 23a) (Type, Print) 934

28

SUITEB, GLENBURNIE

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Medical 4a. Facility Name (if not institution, give street and number, ty of Death Town, or Location of Death Examiner 15 10 If Under 1 Year If Under 24 Hrs Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days 1 M 2 D 90 Hours Min 1 1 1 Day 1 9 2 2 213-48-0261 MARYLAND Yrs Director Usual Residence of Decedent 28a-f shov 10a, State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho idical Examiner must be notified at Director 1 ☐ Yes 2 🕅 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Jenue 弘 U.S.A 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Armed Forces? ☐ Never Married 2 ☐ Married Completed by Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: 3 X Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. within 7 Elementary/Seconday (0-12) College (1-4 or 5+) GOODWILL TYPEST traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) SCRIMGER မ ALBERT MEHRLING permit. Page 1 and 2 should be Department of Health and Mem Important: If item 27 is marke any injury or other traumatic * ANNA 19a. Informant's Name/Relationship (Type, Print)
SUZANNE THOMAS/DAUGHTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROSEDALE, 1901 WILHELM AVENUE 21237 MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State PARKWOOD CEMETERY 4-2-2012 PARKVILLE, 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility CVACH / ROSEDALE FUNERAL HOME 21237 1211 CHESACO AVE ROSEDALE, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Pnysician/ disease or condition Medical resulting in death) Examiner months Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): inding physician ause as the burialician/Medical Box 68760 use yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No for 5 Other (specify) Month Dav Year Pregnant at time of death ed by the a detached f Physi 9 Unknown P.O. signed b Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 s autopsy this certificate 1 Yes 2 No History 25. Was case referred to examiner? Division of Vital funeral director, 26. Place of Death (Check only one) Be Hospital Other: 1 🗌 Yes _2 🗌 NO မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27, Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation within 24 hours after death To the Funeral Director: Completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) edical 29a. Certifier Semifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Septifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signatu License numbe

State

Registrar

filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death MARCH Physician/ RANCES Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE **ESSEX** RIVERVIEW NURSING HOME If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Social Security Number 7, Age (In yrs. last birthday) **Funeral** Months Hours Min. 218-18-8650 87 Yrs. Director 1 M 2 X F 2-9-1925 MARYLAND shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland Director notified PARKVILLE 28a-f MD BALTIMORE 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 must be 23a 9507 FULLERDALE AVE 21234 U.S.A. items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Black White etc. þ ō 1 Never Married 2 Married Yes 2 XNo filed within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: WHITE Specify. "natural" 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working Ith and Mental Hygiene.
27 is marked other than "r traumatic event, the Med life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) OWN HOME 8 HOMEMAKER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname ပ FOGERTY IRENE HENDERSON **JAMES** Page 1 and 2 should be SON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOHN ROBERT STICHEL, JR of Health a 21237 714 CHESACO AVENUE ROSEDALE, MD other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of Important: If it any injury or o ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State METRO CREMATORY 4-3-2012 CATONSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME Signature / Funeral service Licensee 21237 1211 CHESACO AVE ROSEDALE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) xaminer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last the burial-trai Due to (or as a consequence of) physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No

9 Unknown for Month Year 5 Other (specify) Day Pregnant at time of death detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ be Division of Vital Records, 1 ☐ Yes 2 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy has funeral director, page 2 certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 No 2 1 Yes 1 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 3 Inpa 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 2 Accident injury 5 Pending work? 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: Al Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in by determined Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completely f 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of 29c. License numbe 30. Name and address of person who completed cause of death (Item 23a) (Type,

State

Registrar

32. Registrar's Signature

APR 0 3 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] | 2 1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death SHEET Physician/ MARCH AMMY 07:55 M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Mercy Medical Center Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months Days Hours (Month, Day, Year) 214-19-4895 Director 1 □ M 2 🏻 F Maryland 37 Yrs Sept 16, 1974 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "nature?" any injury or other traumatic events. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Anne Arundel 1 Yes 2 X No Maryland Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 204 Stiemly Avenue 21060 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 K No Specify: Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Linda Wright ပ Leo Arvey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Arvey (Mother) 195 Margate Drive, Glen Burnie, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Baltimore, Maryland 4/4/2012 Cedar Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Fun val San Licensee Kevin E Ecker 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road, Pasadena, Md. 21122 MOO175 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ M ETASTAT RECTA disease or condition Medical resulting in death) Examiner Sequentially list conditions, Due to (or selectionsequence of) If any, leading to immedia cause. Enter Underlying Exami Cause (Disease or injury that initiated events the burial-tran To the Hospital or Attending Physician: The law requires that the death certificate be exect Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death signed by the at d be detached fo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 2 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? 1 \(\sum \) Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Natural 28c. Injury at 28d. Describe how injury occurred 5 Pending work within 24 hours after death.

To the Funeral Director: Air completely filled in by the fu 1 Yes 2 No Accident Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Lectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State 3 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #2 per PHY G926 4/04/2012 JH State of Maryland / Department of Health and Mental Hygiene amend #17&19a Per KH C926 4/05/2012 Jh 1 - State Registrar Reg. No. 2. Date of Death 22 Day 2012 Sear MARCH 21, 2012 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ J. SALMON 10:08A M ISAAC Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death
PRINCE GEORGES 4b. City, Town, or Location of Death **Examiner** #2 CAMERON GROVE BOULEVARD UPPER MARLBORO If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday) Days Hours 578-52-7384 73 1938 WASHINGTON DC Director 1 X M 2 🗆 F AUG 1, Usual Residence of Decedent 28a-f show 10h County 10d. Inside City Limits 10a, State 10c. City. Town or Location with the Maryland notified at Director UPPER MARLBORO 1X Yes 2 □ No PRINCE GEORGES MD 10f. Zip Code o 10e. Street and Number 10g. Citizen of What Country? must be 20774 23a CAMERON GROVE BOULEVARD USA items death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Force Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates. or þ 1 Never Married 2 X Married Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 Yes 2 No Specify: Specify: BLACK "natural" 3 Widowed 4 Divorced Completed Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working (Specify only highest grade completed) al Hygiene. life. DO NOT use retired PUBLIC SCHOOL SYSTEM Elementary/Secondary (0-12) College (1-4 or 5+) DC GOVERNMENT the SUPERVISOR event, t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental H
27 is marked of
traumatic ever ပ္ LOUISE HOUGH ISAAC J. SALMON/WIFE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) CAMERON GROVE BOULEVARD UPPER MARLBORO of Health a LINDA L. SALMON/Wife other Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date ᇹ Department of Important: If it any injury or c 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place SUITLAND, MD. MAR 31'12 LINCOLN CEMETERY 4 Donation 5 Other (Specify) 22. Name and Address of FacilityLatimore Funeral Services of Funeral Service Licensee Palrella. 91 Baltimore St. Baltimore, MD 21224 2818 E. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine Due to (or as a consequence of): ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and the burial-tran Due to (or as a consequence of) attending physician Physician/Medical Hospital or Attending Physician; The law equires that the death certificate be P.O. Box 68760 use as IE EEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No ō, Month Day Year 5 Other (specify) Pregnant at time of death ed by the all detached f 9 Unknown signed t Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Records, 1 Tyes Completed een 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has h autopsy certificate Yes Division of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred After Natural iniury 5 Pending Accident Investigation within 24 hours after death To the Funeral Director: Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. соmpletely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)

DHMH 17 Rev 06-2011

State

Registrar

29b. Signatur

31. Date filed (Month, Day, Year)

2012 3

APR 0

completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

D41218

MD 6095 Manshalle Dr. Elkridge

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ Theodore Abraham 10:35_a^M Sumberg 2012 March Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Montgomery Bethesda 5802 Wilmett Road 8. Date of Birth (Month, Day, Oct. 1, 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 **X** M 2 □ F Months Days Hours Min New York 069-12-4472 1916 Director Usual Residence of Decedent 28a-f shov 10b. County 10c, City, Town or Location 10d. Inside City Limits at 10a. State Director notified 1 Yes 2X No Bethesda MD Montgomery 10f. Zip Code ò 10e. Street and Number 10g. Citizen of What Country? ms 23a or must be n Funeral USA 20817 5802 Wilmett Road ral", or items? 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Bace - American Indian 11. Marital Status Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2X Married à Maryland 21215-0036 within 72 hours after 1 Yes 2X No Specify: If Yes, Give Year or Dates Specify: White "natural", 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry oe filed wn... ∸al Hygiene. `ar than "r (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the State Department 2 should be filed with and Mental Hygien. 7 is marked other the 5+ Economist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Ray Levy Nathan Sumberg 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9214 Ewing Drive Bethesda, MD 20817 19a. Informant's Name/Relationship (Type, Print) Department of Heath an Important: If item 27 is r any injury or other traumonce. Judith Giuricich/daughter altimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

Final Journey Crematory 04/02/12 Woodbine, MD 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. MD 21029 Clarksville. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ a. Prostate Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Other (specify) Pregnant at time of death signed by the at d be detached for a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an has page 2 autopsy performed?

1 Yes 2 No certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 24 hours after death. Funeral Director: After work?
1 Yes 2 No XNatural 5 Pending iniury Accident Investigation ☐ Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide filled in by determined Medical 1XX Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 — Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 ho

To the Fune (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number March 30, 2012 D37142 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Coleman, M.D. 1355 Piccard Drive Rockville, MD 20850 32. Registrar's Signature 3 2012 State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Hubl Schuerholz Louise Eve 30 10:58 p^M March 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Sykesville Fairhaven 5. Social Security Number If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days 1 🗆 M 2 💢 F Months Hours Min Feb 10. Maryland 1923 Director 216-16-0651 89 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits with the Maryland notified at Director Carroll MD Sykesville 1 Yes 2 XNo 10e Street and Number 10f. Zip Code 0 10g. Citizen of What Country? must be 23a Funeral USA 7200 3rd Avenue #0403 21784 items ? death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian the Medical Examiner Armed Force Black White etc. and Mental Hygiene. is marked other than "natural", or ð 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 hours after 1 ☐ Yes 2 XNo Specify: Specify: White 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ၉ Franz Hubl Bertha Bild ige 1 and 2 should be nt of Health and Mer I: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) C. Jeanne Rosenwald/daughter 380 Pine Reach Drive Kilmarnock, VA 22482 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) permit. Page Department o Important: If any injury or injury or Final Journey Crematory 04/03/12 Woodbine, MD 21. Signat of Funeral Service Lice 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD MO1251 MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Circhosis Priysician/ Ocurs disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause Disease or impury Examine Due to (or as a consequence of): The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 5 Other (specify) Month Day Year Pregnant at time of death 4 ☐ Pregnant g ☐ Unknown signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed should been 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s autopsy performed has this certificate 1 Yes 2 No 2 2 Hospital or Attending Physician: 25. Was case referred to medical director. 26. Place of Death (Check only one) Be examiner? 1 ☐ Yes 2 No Hospital 은 1 Inpatient 2 ER/Outpatient 3 DOA 4XNursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After injury work? 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: Aft completed filled in by the fur Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide

P.O. Box 68760 Records, Division of Vital

Registrar

Medical

State APR 03

29a. Certifier

(Check only one 29b. Signature and title o

determined

34849

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

City or Town, State)

ddress of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's

1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician/ INAM Schindler Marie Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Hospita 8. Date of Birth Birthplace (State or Foreign Country) Funeral Min Director 217-20-8616 1 🗆 M 2 🕱 F 85 February 24,1927 Maryland Usual Residence of Decede or 28a-f show notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Dundalk 1 Yes 2 XNo Maryland Baltimore 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? items 23a or ner must be n Funeral 21222 3430 Yorkway USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Was Deceuc... Armed Forces? Yes 2 X No 14. Race - American Indian, 11. Marital Status er than "natural", or iter the Medical Examiner Black, White, etc. þ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: White Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working should be filed within 72 and Mental Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 10 years Housewife Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev ည Lula Hoffman John Hoffman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3430 Yorkway, Dundalk, Maryland Kenneth Schindler Sr. Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Apri^{Date}5, 1 XBurial 2 Cremation 3 Removal from State Dundalk, Maryland Oak Lawn Cemetery 2012 ☐ Donation 5 ☐ Other (Specify) ature of Juneral Service Lio once. ²² Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. LAD 21222 23a. Part 1. Enter the discusse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due 🖟 **Examiner** Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examir burial-tran Due to (or as a consequence of) physician s the burial Physician/Medical The law requires that the death certificate be Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Dav Year signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? à Division of Vital Records, 1 X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s autopsy performed? Yes 2 X No has certificate 1 Yes 2 No Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 X No ည 1 X Inpatient 2 ER/Outpatient 3 DOA 24 hours after death.

Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred X Natural 5 Pending injury 1 Yes 2 No Accident Investigation filled in by the 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one 29b. Signature and title certifie 29c. License number 29d. Date signed (Month, Day, Year) 21 Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore MD Day, Year) 2012 31. Date filed (Month, Day,

DHMH 17 Bev 06-2011

Registrar

APR 0

3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month Sylvia Sutherland 201 11:59 March Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death NA Future Care Nursing Home Coldspring Baltimore Birthplace (State or Foreign Country) TTA 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth **Funeral** 1 🗆 M 2 🗓 F Months Days Hours Min. 056-24-1168 Director 85 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County Director 10c. City. Town or Location 10d. Inside City Limits 1 🗓 Yes 2 ☐ No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21218 1508 Shadyside Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Force Black, White, etc. African þ 1 Never Married 2 Married 2 1 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: American 3 XWidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) 12th Grade (0-12) College (1-4 or 5+) Homemaker other homes Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ David 0. Southerland Leslie Adeliade Hailstalk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zio Code, 1508 Shadyside Road Baltimore, MD. 21208 Arthur Sutherland-Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Quatico Nat 1 Cem. 1 XX Burial 2 Cremation 3 Removal from State Traingle, VA 04-07-12 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home P.A. 638 N. Gilmor Street Baltimore, Maryland 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph sician Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease of impury that initiated events resulting in death) Last and the burial-trar Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year signed by the aid be detached. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown cate has been sig page 2 should b Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performe death? certificate 2 1 No Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 1 🔲 Yes Other ည i 24 hours after death.

e Funeral Director: After this alleted filled in by the funeral dii 1 Inpatient 2 ER/Outpatient 3 DOA 4 Vursing Home 5 Residence 6 Other (Specify) 27. Mann of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Tyes 2 🗆 No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 only one 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatur nd title of certifier 29d. Date signed (Month, Day, Year, Jan and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 () | 2 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 1 200 AM 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore 8. Date of Birth
(Month, Day, Year) Security Number 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 1 M 2 X F Min. Hours Director Usual Residence of Deceden 28a-f shov 10a. State 10b County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland must be notified at 10d. Inside City Limits Completed by Funeral Director 1 Yes 2 □ No unda 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 7832 Savanasi 222 21 ural", or items a Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give
Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Tes 2 No Specify: and Mental Hygiene.

is marked other than "natural", 3 Widowed 4 □ Divorced Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical Is once. 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) Unmesti 12 Homemak Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame ပ္ Anthony 19a. Informant's Name/ ationship (Type, Print) 19b. Mailing Address (Street and Number or Rural R - Number, City or Town, State, Zip Code) horabik lov 20a. Method of Disposition 20b. Place of Disposition (Name of 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) cemetery, cremato 22. Name and Address 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition ovenan Medical resulting in death) **Examiner** rid Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury signed by the attending physician and de detached for use as the burial-transit nevter that initiated events Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be exect resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Pregnant at time of death Month Dav 1 ☐ Yes 2 🗷 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 NJnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2.3 autopsy performed? Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 \(\sum \) Yes 卢 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) San's house 27. Manper of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work?
1 Yes 2 No Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: T. the Left of my known (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 04/03/1 1) 005517 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SERASTIAN MIOC 3023 Eastern 31. Date filed (Month, Day, Year) 12. Registrar's Signature State APR 0 3 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death State
Registrar 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) April 2012 5:45 Scanne11 Physician/ Donald Leon Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Anne Arundel Glen Burnie North Arundel Rehabilitation Center Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 5. Social Security Number (Month, Day, Year) **Funeral** 76 Maryland 1935 1 X M 2 □ F AUG 23, 219-32-7343 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 28a-f show 10b. County 10a. State Examiner must be notified at Director 1 Yes 2 No Pasadena Anne Arundel MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō USA 21122 Funeral 23a 8093 Woodholme Circle Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No within 72 hours after death Black, White, etc. X Yes Yes, Give Completed by 1 Never Married 2 M Married ō 1 ☐ Yes 2 😾 No Specify: 21215-0036 White If Yes, Give Year or Dates 1957-61 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) traumatic event, the Medical Defense Contractor College (1-4 or 5+) Elementary/Secondary (0-12) Electronics Technician 18. Mother's Name (First, Middle, Maiden Surname) and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) Baltimore, Maryland Giese Marie Anna ပ Scannell Richard Eugene 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pasadena, MD 21122 8093 Woodholme Circle Christine K. Scannell, wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Page 1 a
Department of I
Important: If ite
any injury or ot
once. 1 X Burial 2 Cremation 3 Removal from State Lake View Memorial Pk. 04/10/12 Sykesville, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility MacNabb Funeral Home, P.A. 21. Signature of Funeral Service Licensee George MacNabb 301 Frederick Road, Catonsville, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final neumoni Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 88 23d. Date of delivery IF FFMALE: 23c. If yes, outcome of pregnancy for use Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ 23b. Was decedent pregnant Day Month in the past 12 months?

1 Yes 2 No Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed by 1 ☐ Yes 2 ☐ No 3 🔀 Probably 4 ☐ Unknown by Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perforn this certificate has 2 No 1 Yes Yes 26. Place of Death (Check only one) 25. Was case referred to medical filled in by the funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No မ 28d. Describe how injury occurred 28a. Date of injury 28b. Time of 27. Manner of Death Certificate: (Month, Day, Year) work iniury 1 Natural 5 Pending 1 Yes 2 No s after death. Investigation __ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office Suicide 4 Homicide determined building, etc. (Specify) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 24 hours a Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Medical 29a. Certifier within 24 hou

To the Funer

completely file Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and who completed cause of death (Item 23a) (Type, Print) Oakwood Road, Glen Burnie MD21061 7845 avanay 32. Registrar's Ignature 3 2012 APR 0 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For Amend Item 29d State of Maryland 0 Penarth State Registrar Certific	nent of He cate of De	alth and M ath	ental Hygi	ene 201	2 103 2
Е	Physicia	m/	1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death
	Medic	cal	Elsie May Spates 4a. Facility Name (if not institution, give street and number) 4b.	O: 7		March	6, 201	
	Examin	ier	Montgomery General Hospital	Olney	ocation of Death		4c. County of Dea	
B	Funeral Director				f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	'ear) Co	rthplace (State or Foreign ountry)
	d It	L	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			oct 1, 1	911 Wash	nington, DC
	larylar 3a-f sh ified a	Director	MD Montgomery Silver Spr					1 ☐ Yes 2 🚨 No
	the N a or 28	I Dir		Of. Zip Code		10	lg. Citizen of What Co	ountry?
	th with ns 23 must	Funeral	15300 Pine Orchard Drive; 1B	20906			USA	
980	72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho ledical Examiner must be notified at	by	Armed Forces? If Yes,		anic Origin? (Spec Mexican, Puerto F Specify:		14. Race - Ame Black, Whit Specify: Wh :	e, etc.
Baltimore, Maryland 21215-0036	s filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	(Specify only highest grade completed) (Give kind of	T use retired)	on ing most of workin	g 1	6b. Kind of Business	_{/Industry} unk
land 2	be filed v ental Hyg rked othe ic event,	To Be	17. Father's Name (First, Middle, Last) Richard Blankenship		8. Mother's Name	(First, Middle, Ma	,	
Mary	1 and 2 should be file of Health and Mental I fitem 27 is marked o r other traumatic eve		19a. Informant's Name/Relationship (Type, Print) June Liverette – daughter 19b. Mailing Ad 6112	dress (Street and Thomason	Number or Rural n Dr; Cl	Route Number, C arksvill	City or Town, State, Zi e, MD 210	p Code) 29
imore,	permit. Page 1 am Department of He Important: If item any injury or othe once.		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	y or other place)			0c. Location - City o	Town, State
Balti	permit. Departr Imports any inji						omy Board Simore, MD	21201
	thysician/		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart fajlure. List only one cause on each line. Immediate Cause (Final disease or condition a	1	such as cardiac or	respiratory arrest	t,	Approximate Interval Between Onset and Death
	Medical Examiner		resulting in death) Due to (or as a consequence of):	a 1971	1 Thro	mbosis		2 days
	uted d ansit	Examine	Exquentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	J				
09	ate be executed bhysician and the burial-transit	dical Ex	resulting in death) Last Due to (or as a consequence of):					
9289	tificate ng phy e as th	Med	IF FEMALE:					
. Box 6	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi		23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ecto	opic pregnancy ner (specify)			23d. Date of de Month	livery Day Year
ds, P.O.	requires that the been signed by should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underly	ying cause given	in Part I.			o the cause of death? Probably 4 1 Unknown
Division of Vital Records,	The law requi ate has been page 2 shoul	Completed				24a. Was an autopsy perform	prior to death?	utopsy findings available completion of cause of
ita	sician: The certificate irector, pag	Be	25. Was case referred to medical examiner? Hospital:	Other:	of Death (Check			
of V	y Phys er this eral di	e: To	1 ☐ Yes 2 🖟 No Hospital: 1 💢 Inpatient 2 ☐ ER/Outpatient 3 ſ 27. Manner of Death 28a. Date of injury 28b. Time of	28c. Injury at		ne 5 🗌 Residen 8d. Describe how	ce 6 Other (Spec	cify)
ono	anding sath. rr: Afte he fun	ficat	1 X Natural 5 ☐ Pending (Month, Day, Year) injury 2 ☐ Accident Investigation M	work?	s 2 🗆 No			
Divisi	tal or Attors after de al Directored in by t	l Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, fa building, etc. (Specify)	actory, office	2	8f. Location (Stre City or Town,	et and Number or Ru State)	ral Route Number,
	To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical	29a. Certifier (Check only one) 1. Certifying Physician: To the best of my knowledge, death occurr 2 Medical Examiner: On the basis of examination and/or investigation 3 Certifying Nurse Practitioner: To the best of my knowledge, death	on, in my opinion, o	death occurred at t	he time, date and	place, and due to the	cause(s) and manner stated.
	Note to the contract of the co		29b. Signature and title of certifier	29c. License nu			d. Date signed (Montarch 6, 20	
_	10		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Yuanue Zhang Blo Prince 31. Date filed (Month, Day, Year) APR 0 3 2012	= Philir	Drive	, 01	ney MD	20832
	Stat Registra		31. Date filed (Month, Day, Year) APR 0 3 2012	1		,	•	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician/ APRIL 9:42 A.M. JOAN ELIZABETH SANJUAN 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ROSEDALE BALTIMORE RANKLIN SQUARE HOSPITAL If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign ocial Security Number **Funeral** Hours JUNE 23, 1943 MARYLAND 212-42-0118 68 **Director** 1 🗆 M 2 🗶 F Usual Residence of Dece or 28a-f show notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 No MD. BALTO. KINGSVILLE 10e, Street and Number 10f. Zip Code ŏ 10g. Citizen of What Country? ritems 23a or ner must be n Funeral 7016 SUNSHINE AVENUE 21087 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Examiner Armed Forces? Black, White, etc. ō by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WHITE 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify "natural", 3 Widowed 4 Divorced Completed 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) th and Mental Hygiene.
27 is marked other than traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) 12TH HOMEMAKER HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 WILLIAM G. ENDERS EDNA M. VITELOZZI 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Department of Health ar Important: If item 27 is any injury or other trau CHRISTOPHER J. SAN JUAN SON 1706 SUNSHINE AVENUE KINGSVILLE, MD. 21087 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) HIGHVIEW 4-7-2012 FALLSTON, MD. 4 Donation 5 Other (Specify) 22. Name and Address of Facility SCHIMUNEK FUNERAL HOME, INC. Signature of Funeral Service NOTTINGHAM, MD. 21236 9705 BELAIR ROAD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPSIS Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner HRS BACTEREMI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami burial-transi Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last physiciar Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Live Birth 2 Fetal death Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day Year be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 s autopsy performed 1 Yes 2 No 25. Was case referred to medica funeral director, Be 26. Place of Death (Check only one) examiner?
1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) P Hospital 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manne of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 \square Pending work? 1 ☐ Yes 2 ☐ No s after death. Accident Investigation filled in by the Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 9000 FRANKLIN SQUARE DRIVE BALTIMORE, MD 2/237 MD PREETAM JOLEPALEM

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

Registrar's Signature

32

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year AM CLARENCE JOSEPH SIWA 201 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Ranklin Souake Hospita sed If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 **X**M 2 □ F Min. Months Days Hours 88 APRIL 8, 1923 Director OHTO 284-16-6058 Usual Residence of Decedent 23a or 28a-f show ist be notified at 10a. State 10b. County 10c. City. Town or Location Director 10d. Inside City Limits MD. BALTO. PARKVILLE 1 ☐ Yes 2**X** No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? CALVERT COURT Funeral Examiner must 8810 WALTHER BLVD. UNIT 2325 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
Yay Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ō þ 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 🙀 No Specify: 3 Widowed 4 □ Divorced 1941-1945 Completed Specify: WHITE the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) BREWER and Mental Hygien is marked other th BEER COMPANY 10THBe Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ þe traumatic CASPER SIWA MARY WALCZAK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a ROSEMAE NEELS FRIEND 8810 WALTHER BLVD. UNIT 3213 PARKVILLE, MD. 21234 permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other t Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 XOther (Specif) ENTOMBMENT GARDENS OF FAITH 4-4-2012 BALTO.MD. Signature of Funeral Service Licensee 22. Name and Address of Facility SCHIMUNEK FUNERAL HOME, INC. 9705 BELAIR ROAD NOTTINGHAM, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician schemic disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner monari Esquantiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): the Hospital or Attending Physician; The law requires that the death certificate be executed Oni burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician thed for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) Month Day Year 4 Pregnant : 9 Unknown detached 9 Unknown s been signed by should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? Yes 2 No I ☐ Yes 2 🔀 No 25. Was case referred to medical examiner? æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🔀 No မ 1 Tes 1 X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation within 24 hours after deat To the Funeral Director: 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. Shiven Patel 9000 Franklin 5 Square drive Baltimore MD 21237 31. Date filed (Month, Day, Year,

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 03 2012 р м 10:30 Joan Schek Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Good Samaritan Nursing Center Baltimore Baltimore 5 4 1 Birthplace (State or Foreign Country)
 MD Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 □ M 2 🗓 F Months Days Hours 07/01/1933 Director 216-28-8831 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location notified at 10d. Inside City Limits Director 1 X Yes 2 No MD N/A Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? the Medical Examiner must be 23a Funeral U.S.A. 6201 Chinquapin Parkway 21239 filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ō þ 1 X Never Married 2 A Married 1 ☐ Yes 2 K No Specify. white "natural", Completed 3 Widowed 4 Divorced Specify: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) 12 College (1-4 or 5+) Telephone Operator City of Baltimore other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be file h and Mental H. 7 is marked ot ည Schek Gertrude Schmo11 Mary Department of Health and Important: If item 27 is n any injury or other traumonce. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen Montgomery, Personal Rep. 6203 Chinquapin Parkway Baltimore, MD 21239 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2 🖾 Cremation 3 D Removal from State 04-03-2012 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Svc. Corp. Towson, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Leonard J. Ruck, Inc. Desardia 5305 Harford Road, Baltimore, MD 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a conse uence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of burial-transit Due to (or as a consequence of) resulting in death) Last physician Physician/Medical the aftending ph IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 month Day 2 No signed by the a Id be detached f g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? 2 N 2 No 1 Tyes Yes 25. Was case referred to medical To Be 26. Place of Death (Check only one) Hospital 2 No Other: within 24 hours are www.

To the Funeral Director: After this c 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Mann of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending 1 V Natural 5 Pending injury 1 🗆 Yes 2 🗌 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

ARW 2 DC

Registrar DHMH 17 Rev 7/2009

State

r

260

31. Date filed (Month, Day, Year)

20

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Division of Vital Records,

Blud

32. Registrar's Signature

Baltianole,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1 Decedent's Name (First Middle Last) 3. Time of Death 2012 29, Scally March 6:00 p.M Gerard Thomas 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Harford Co. Bel Air 102 Glenmore Court If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Social Security Number Hours 218-28-6175 1 **X** M 2 □ F 80 02/12/1932 Maryland Usual Residence of Dec 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No MD Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21014 102 Glenmore Court 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1 Never Married 2 M Married 1 ☐ Yes 2 X No Specify: White Specify: 3 Divorced Year or Dates 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Oil Driver Salesman 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ellen Flynn Francis Scally 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21090 Mrs. Ellen T. Clements/Daughter 463 Mary Kay Court Linthicum, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specifyentombment 04/04/2012 Cedar Hill Cemetery Brooklyn, MD 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signsture of Funeral Service Licenses MO1479

Physician/ Medical **Examiner**

Physician/

Medical

Director

Funeral

by

Completed

Be

ဂ္

Examiner

Funeral

Director

or 28a-f st notified

5 is 23a c must b

9

"natural"

ed other than 'event, the Me

Ith and Mental F 27 is marked o traumatic eve

item 27 other tra

Department of H Important: If ite any injury or ot

the Maryland

death v

and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

g physician and as the burial-tran use ed by the a filled in by

on of Vital Records, P.O. Box 68760 certificate has been signe irector, page 2 should be tor: After the the funera $\chi \setminus$

Divis	To the Hospital or Att	within 24 hours after d	To the Funeral Direct
)	× X	,

completely

	Ollena	Holanyu Se	rvices PA; 1 2nd	Ave SW, GJ	en Burni	ie, MD 21061
	23a. Part 1. Enter the disease, or comp shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a consequence of):				Approximate Interval Between Onset and Death
Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): c. Due to (or as a consequence of): d				
ıysician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		Ectopic pregnancy Other (specify)		23d. Date of de Month	livery Day Year
Completed by Pr	Part II. Other significant conditions co	ntributing to death but not resulting in the un	derlying cause given in Part I.		2 □ No 3 □ P	to the cause of death? Trobably 4 Unknown Tropsy findings available
Compl				24a. Was an autopsy performed?	prior to death?	completion of cause of
Be	25. Was case referred to medical		26. Place of Death (Che	ck only one)		
10	examiner? 1 Yes 2 Yo	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	3 DOA Other:	Home 5 Residence	6 ☐ Other (Spec	ify)
Certificate: 1	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year) 28b. Time of injury	28c. Injury at work? M 1 Yes 2 No	28d. Describe how inju		
	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, stree building, etc. (Specify)	t, factory, office	28f. Location (Street a City or Town, Sta		ral Route Number,
Medical	(Check 2 Medical Examir	ician: To the best of my knowledge, death or ner: On the basis of examination and/or investig e Practitioner: To the best of my knowledge, or	ation, in my opinion, death occurred	at the time, date and place	ce, and due to the	cause(s) and manner stated
	29b. Signature and title of certifier		29c. License number	29d. D	ate signed (Montl	h, Day, Year)
	D. 15	3	1 33555	112		

State

Registrar

31. Date filed (Month, Day,

APR 0 3 2012

w. M

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Honth Physician/ Benson 12:53 pm Louis DACKS 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Sel ChesADEAKC If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 219-36-9820 Director 1**X**M 2 □ F 70 March 7, 194 10h County 10c. City, Town or Location with the Maryland **Funeral Director** 1 Tes 2 No 10g. Citizen of What Country? ò 23a KReitler Valley 21050 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 2 Yes 2 No Army o. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No If Yes, Give "natural", 3 Widowed 4 Divorced Year or Dates 1959-62 27 is marked other than "natural traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Medical Field Elementary/Secondary (0-12) College (1-4 or 5+) ENTrepreneur Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည SACKS Belle LICBEN DOD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, R. CArol SACKS VAlley 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1
Department of
Important: If it
any injury or o 1 Burial 2 Cremation 3 Removal from State 4-3-2012. 4 Donation 5 Other (Specify) 22. Name and Address of Facility Charks 5. Zannino Head 21. Signature CONKLING ST GA HIMOR NO 21224 1 23a. Part 1. Enter the ase or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failur 1 Immediate Cause (Final disease or condition resulting in death) emplications of Lune Physician/ Medical Examiner OB Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to to by the attending physician and stached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day ior: After this certificate has been signed by the a the funeral director, page 2 should be detached? Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? To Be Completed by Diabetes 1 Yes 2 No 3 Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 🗆 No Yes 2 No 1 🗌 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 2 X No 1 ☐ Inpatient 2 KER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death

To the Funeral Director; After 1 Natural
2 Accident
3 Suicide 5 Pending Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29d. Date signed (Month, Day, Year) D0057 223 2012 ne and address of person who completed cause of death (Item 23a) (Type, Print) ChesApente, DRIVE BELAIN MD 500 UPPCA Fernin Barrucio 31. Date filed (Month, Day, Year) State Registrar ↑

▼ DHMH 17 Rev 06-2011

200

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Month 7:35 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 586 CYN WOOL COX Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Days Min. 1 M 2 L Country) Maryland Director Usual Residence of Deceder permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I fitem 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2🔽 No MD Talbot Cordova 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? : If item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must b Funeral 12579 Blades Rd. 21625 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 ANo Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) waitress/short order cook restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Roland Ellsworth Marshall Sr. Nancy Anne Newman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rebecca Greathouse - daughter 12579 Blades Rd; Cordova, MD 21625 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Interval Between Metas Immediate Cause (Final Onset and Death Physician/ Cancer disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Physician/Medical Examiner Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or iinjury that initiated events use as the burial-transit and Due to (or as a consequence of): resulting in death) Last attending physician certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 1 ☐ Live Birth 2 ☐ Fetal deal 4 ☐ Pregnant at time of death 9 ☐ Unknown in the past 12 months?

1 Yes 2 No To the Hospital or Attending Physician: The law requires that the death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Nown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 2 No Yes 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other Specifi HospiceHouse 2 XNo 1 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending injury 2 Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Excertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number March 20 Lakshmi DO 5774 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NAHTANAPOTAN 219 S. WASHINGTONST, EASTON MD 2160 AKSHMI 31. Date filed (Month, Day, Year) . Registrar's Signature State

Registrar

Box 68760

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** momas 4 Rosie 2012 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Johns Hopkins Bayview Medical Center Baltimore 8. Date of Birth (Month, Day, Year) Dec. 8, 1929 5. Social Security Number 217-28-9517 6. Sex If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🛣 F 82 MD Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location ms 23a or 28a-f show must be notified at 10d. Inside City Limits MD Baltimore Baltimore Director 1 Yes 2 No 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 8043 Bank Street 21224 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Yes 2 If Yes, Give Year or Dates: or P 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White þ 3 Widowed 4 □ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry State Employee College (1-4 or 5+) 2yrs Elementary/Secondary (0-12) of Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the M Credit Union Loan Counselor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be unknown Elizabeth Duckworth ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Kleinman /daughter 7 Abbott Road Maynard MA 01754 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of H Important: If ite any injury or otl once. 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery 4/4/12 Baltimore MD er ice Licens 21. Si hature f Funeral 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221 23a. Next. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Acute Respirating Physician Dishess Syndrome week disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Pre umonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury unknown Examine Due to (or as a consequence or, g physician and as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 3 Ectopic pregnancy in the past 12 months? Month Year Dav Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Atrial Abrillahun 1 TYes 2MNo 3 ☐ Probably 4 ☐ Unknown Completed should Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? Stroke 24a. Was an page 2 s has 1 Yes 1 ☐ Yes 2 😿 No al or Attending Physician: T s after death. I Director: After this certificate 25. Was case referred to medical completely filled in by the funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of Injury 28b. Time of Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 2 Accident 5 Pendina Injury investigation 1 🗌 Yes 2 🗌 No 3 Suicide Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 24 hours a Funeral D 114 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) To the I within 2 To the I 29b. Signature and title of certifier 29c. License number 1740436153 2012 U 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 1/2001

11595

State

32. Registrant Signature

4940 Eastern Avenue, Baltimore, MD, 21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental H	ygiene
1 - State Registrar Certificate of Death	Reg. No. 2012 10320
1. Decedent's Name (First, Middle, Last) 2. Date of D Month Modical 1. Decedent's Name (First, Middle, Last) 2. Date of D Month Modical	Day Year
Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	30 7012 0245 M
University of MARULAND Medical Center Baltimore	N/A
Funeral Director 5. Social Security Nurseber 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of B (Month, Days Hours Min. 1) Month, Days Hours Min. 10 Month, Days Month, Days Min. 10 Month, Days Mo	
Liquel Registeres of December 4	13,1944 Illinois
10a. State 10b. County 10c. City, Town or Location 10c. Ci	10d. Inside City Limits
Pur de la	1 ☐ Yes 2 🔀 No
1943 Inverton Road 1943 Inverton Road 21222 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? If Yes specify Cuban Mexican Buerto Rican etc.)	United States
12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or Not Armed Forces? 14. Marital Status 15. Was Decedent of Hispanic Origin? (Specify Yes or Not Armed Forces?) 16. Yes, specify Cuban, Mexican, Puerto Rican, etc.)	0- 14. Race - American Indian,
1 Never Married 2 X Married 1 Never Married 2 X Married 1 Yes 2 X No Specify:	Black, White, etc. Specify:
3 Widowed 4 Divorced Fear or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 17 Year or 18 Years 18 Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 18 Years 19 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) 19 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired)	White 16b. Kind of Business/Industry
Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+)	,
The political properties of personal properti	Criminal Justice a, Maiden Surname) unkn
18. Mother's Name (First, Middle Light of the file of	GIIKII
The proof of the p	per, City or Town, State, Zip Code) k, Maryland 21222
Compteny crematory or other place)	20c. Location - City or Town, State 2 Owings Mills, MD
Service of the place of the pla	I
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory a shock, or heart failure. List only one cause on each line.	
Immediate Cause (Final disease or condition	Onset and Death
Medical resulting in death) Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	
Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
d create b	
The part of the pa	23d. Date of delivery
of the post of the	Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	tobacco use contribute to the cause of death?
equire establishment by the control of the control	Yes 2 M No 3 □ Probably 4 □ Unknown
The law requires The law requires Completed Completed 1 \[\text{Yes} \] Yes	s an 24b. Were autopsy findings available propsy prior to completion of cause of death? 2 No 1 Yes 2 No
25. Was case referred to medical examiner? 1 Yes 2 No	
Yes 2 No 1 Minpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Res	idence 6 Other (Specify) how injury occurred
Dec 25 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	
28d. Describe 27. Manper of Death 1 Matural 2 Accident 1 Nestigation 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location City or To	Street and Number or Rural Route Number, wn, State)
The course of predicts of the past 12 months? The	and place, and due to the cause(s) and manner stated.
	29d. Date signed (Month, Day, Year)
Mella Malla 1115 1316246598	11/Arch 50, 2012
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Melsian Shollia W. 22 South Greene Street Baltimore, M 31. Date filled (Month, Day, Year) 32. Registrar's Streature	1051s barklusa
State Registrar APR 0 3 2012 32. Registrar's Signature 33. Date filed (Month, Day, Year) 32. Registrar's Signature 33. Reg)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last 2. Date of Death Physician/ 3:35 AM Ori Medical 4a. Facility Name (if not institution, give street and number) Examiner Town, or Location of Death 4c. County of Death Hophins Morr 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Yemen Repulic of 6. Sex If Under 24 Hrs 8. Date of Birth (Month, Day, **Funeral** 80 107-36-3434 1 🔀 M 2 🗆 F **Director** 3-7-1932 Usual Residence of Deceden show 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits notified at Director MD 28a-f Baltimore 1 X Yes 2 □ No 10e. Street and Number o 10f. Zip Code ms 23a or must be r 10g. Citizen of What Country? Funeral 21231 Wolfe Street 621 S. USA items 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, the Medical Examiner Black, White, etc ō þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. Baltimore, Maryland 21215-0036 White 1 Yes 2 XNo Specify. Completed 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) U.S. Maritime Maritime 8th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Abdulaziz Thabit unk. traumatic 19a. Informant's Name/Relationship (Type, Printnephew 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Abdulaziz Mohammed Alsoufi P.O.BOX 708 Jeddh 21577 Saudi Arabia other t 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or oth Page 1 cemetery, crematory or other place)
Oak lawn 1 Burial 2 Cremation 3 Removal from State 4/3/2012 Baltimore, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility . ZanninoJr.FH. Baltimore,MD 21224 dress of Facility Joseph N Conkling St., aria 263 S. 23a. Part 1. Enter the dispase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Freumonia disease or condition Medical resulting in death) Examiner spirator Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Exami burial-tran and Due to (or as a consequence of) attending physician Physician/Medical certificate be Box 68760 use as the 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death Day the P.0. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? [Ω Records, 2 No 1 🗆 Yes 3 Probably 4 D Unknown Completed been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 has autopsy performed death? within 24 hours after death.

To the Funeral Director: After this certificate 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA completely filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 2 🗆 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 [only one) 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 06-2011

State

30. Name and addres

Gia i

10

APR 0 3 2012

arks

600 North Wolfe Street Baltimore MD21297

completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Physician/ Alemida Manuevaam Medical City, Town, or Location of Death 4a. Facility Name (if not institution give street and number Examiner 4c. County of Death Grener altimore If Under 1 Year If Under 24 Hrs. Age (Ir last birthday Birthplace (State or Foreign Country) Date of Birth **Funeral** Min Director show 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No 28a-f fimore 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ō Funeral .408 items 23a 2/201 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. If $|\mathcal{A}\mathcal{M}\mathcal{A}| = |\mathcal{A}\mathcal{A}| |\mathcal{A}\mathcal{A}\mathcal{A}|$ Baltimore, Maryland 21215-0036 14. Race - American Indian, Armed Forces? Black, White, etc. ō þ 1 Never Married 2 Married 1 ✓ Yes 2 ☐ No Specify: If Yes, Give Year or Dates tispanic "natural", Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NO) use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 00 K and Mental Hygie is marked other Be Middle 2 nueva Page 1 and 2 should Iment of Health and Me 19b. Mailing Address (Street and Number or State, Zip Code) Department of Health an Important: If item 27 is any injury or other trauonce. Apt. 408, Bultimore, 1100 Yennsylvanias Ave. 20a. Method of Disposj Place of Disposition (Name of 1 Burial 2 Cremation 3 Removal from State matory or other place 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 23a. Part 1. Enter the diseashock, or heart failule or complications that caused the death st only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to Examiner Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or iinjury that initiated events coulting in deeth). Examine and Due to (or as resulting in death) Last physician Physician/Medical The law requires that the death certificate be P.O. Box 68760 the attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 month Pregnant at time of death Day Month Year 1 ☐ Yes 2 ► 9 ☐ Unknown the Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Division of Vital Records, 1 Yes 2 ─ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform within 24 hours after death.

To the Funeral Director: After this certificate to completed filled in by the funeral director, page To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 Other: 2 No 1 Inpatient 2 DER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending Investigation 6 Could not be 1 Yes 2 🗌 No Accident filled in by the 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a, Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month) 8 7 ddress of person who completed cause of death (Item 23a) (Type, Print) 2 0

State

Registrar

3

32. Registra 's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Mildred Ray Wiseman April 2012 2:35 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center Baltimore Towson 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months 215-07-1170 Davs Hours Director 91 1 □ M 2 😿 F Aug. 22, 1920 Baltimore, MD Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10c. City, Town or Location Director 10d. Inside City Limits MD Baltimore Parkville 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 7710 Queen Anne Drive 21234 United States ral", or items 2 Examiner mus 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Force Black, White, etc. þ 1 Never Married 2 Married 72 hours after ☐ Yes 2 XNo Baltimore, Maryland 21215-0036 ian "natural", i 1 ☐ Yes 2 X No Specify: If Yes, Give 3 ₩ Widowed 4 Divorced Specify: White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumation. Elementary/Secondary (0-12) College (1-4 or 5+) At Home Homemaker 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Harry Hoerl Pauline Hoffman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janice Roberta-Daughter 2011 Highland Ridge Dr. Phoenix, MD 21131 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State April 1 X Burial 2 Cremation 3 Removal from State Gardens of Faith Rosedale, MD Donation 5 Other (Specify) 2012 Cemeterv 21. Signature of Funeral Service Licensee Evans Funeral Chapel & Cremation Services 8800 Harford Rd. Parkville, MD 21234 a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, slock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Interval Between Onset and Death Physician/ disease or condition resulting in death) ASPIRATION PNEJMONIA Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 month 1 Yes 2 No 3 D Ectopic pregnancy detached for Pregnant at time of death 5 Other (specify) Month Dav Year 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed b 23e. Did tobacco use contribute to the cause of death? Completed by DIABETES MELLITUS 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ №6 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performed 1 Tes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: 4 Nursing Home 5 Residence 6 Lether Specify HOSA (မ 1 Inpatient 2 ER/Outpatient 3 DOA After this filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 2 No 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pendina injury s after death. Accident Investigation 2 Acciden 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number. 24 hours Medical rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the bout within 2 To the 1 29b. Signature and title of certifier 29c. License number Tr 18

State Registrar 31. De filed (Month, Day, Year)

3 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 18 per fh e926 4-10-11 vt. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month 0 Physician/ Sharon D. Walker DO M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Genesis Randallstown Randallstown Baltimore Social Security Number 9. Birthplace (State or Foreign Country) Marylang If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral 7. Age (In vrs. last birthday) 1 M 2 XF Days Hours (Month, Day, Year) 09/01/1948 214-50-9875 63 **Director** Usual Residence of Decedent or 28a-f show notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. and the file 23a or 28a-f show ant if item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Carroll Sykesville Md. 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 21784 5812 Victor Drive 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: Completed 3 ★ Widowed 4 □ Divorced Year or Dates. 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 2Yrs. Budgeting Patient Accounting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)

Betty Jane Seaton

Sucon M. Gibride ပ Robert J. Ogden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5812 Victor Drive Sykesville, Md. 21784. Jeannette M. Walker(Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 04/02/12 Sykesville, Md. All County Cremation 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Haight Funeral Home & Chapel P.O. Box 195 Sykesville, Md. 21784. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): and Due to (or as a consequence of): resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be to within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia completed filled in by the funeral director, page 2 should be detached for use as the burn. Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Pregnant at time of death 1 Yes 2 2 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by HIN 1 Yes 2 No 3 Probably 4 Unknown ESRD 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy COPD 1 ☐ Yes 2 ☐ No Yes 20 ₩ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Hospital Other: Certificate: To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 Yes 2 No 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number MD John D0072109 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9109

DHMH 17 Rev 7/2009

State Registrar Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		4	_ FOI	epartment of Health and M	lental Hygi	ene	10005
			- negistral	Certificate of Death		g. No.	111323
	Physicia		1. Decedent's Name (First, Middle, Last) Sarah Diane Wilcox		2. Date of Death		3. Time of Death 1:59 P M
	Medic	al .	Sarah Diane Wilcox 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	PIMICH	4c. County of Deatl	
	Examin	er	Laurel Regional Hospital	Laurel		Prince	
•	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birtho		8. Date of Birth	9. Birt	hplace (State or Foreign
	Director	ļ.	216-68-0729 1 D M 2 X F 56 Y	s. World Baye House	July 25	, 1955 Floor	rida
	nd how at	. I	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	or Location			10d. Inside City Limits
	larylar 3a-f s ified	ecto	MD Prince George's Laurel				1 🛚 Yes 2 🗆 No
	the M	Ē	10e. Street and Number	10f. Zip Code		ng. Citizen of What Co	untry?
	within 72 hours after death with the Maryland gene. ier than "natural", or items 23a or 28a-f sho ier the Medical Examiner must be notified at t, the Medical Examiner	Funeral Director	14912 Cherrywood Drive	20707		JSA	
	death r item iner n		11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 1 □ Yes	 Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto 	city Yes or No- Rican, etc.)	14. Race - Amel Black, White	
36	after al", or xami	d by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2★ No If Yes, Give Year or Dates.	1 ☐ Yes 2 XNo Specify:		Specify: Whi	te
21215-0036	hours natur dical f	Completed	15, Decedent's Education 16a. I	Decedent's Usual Occupation Give kind of work done during most of worki	na 1	6b. Kind of Business	Industry
218	in 72 e. han "	티	Elementary/Seconday (0-12) College (1-4 or 5+)	fe. DO NOT use retired)	1	Commercial	N/C
	d with lygier ther ti	a l	12 Adn	ninistrative Assistan			A/C
Maryland	oe file intal F ced of	70 E	Alma Leon Jenkins	Bobbie La			
37	nd Me s mar		19a. Informant's Name/Relationship (Type, Print) 19b.	Mailing Address (Street and Number or Rura	il Route Number, (City or Town, State, Zip	Code)
	d 2 shealth a n 27 is ertra		Deborah J. Baker/sister 149	012 Cherrywood Drive	Laureı,	MD 20707	
ore	of He			tonior other place!		20c. Location - City or Woodbine,	
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatto event, the Medical Examiner must be notified at once.		4 Donation 5 Other (Specify)	Journey Crematory 04			
Ba	Depar Impor any ir		21. Signature of Funeral Service Licensee Pure L. H. althe MO1251	22. Name and Address of Facility Going Home Cremation Beverly L. Heckrotte	e, P.A.	CIarksviii	x 784 e, MD 21029
			23a. Part 1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.		or respiratory arres	st,	Approximate Interval Between
1 - 1/4	Physician/		Immediate Cause (Final disease or condition a. Cardiopulmo	nary Arrest			Onset and Death
	Medical Examiner		resulting in death) Due to (or as a consequence of Myocardia)				1 hour
		Jer	if any, leading to immediate Due to (or as a consequence of				- 1,001
	d d ansit	amii	cause. Enter Underlying Cause (Disease or iinjury that initiated events c				
	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	by Physician/Medical Examiner	resulting in death) Last Due to (or as a consequence of):			
09	ate be physic the bu	dica	d				
68760	ertifica ding p	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of de	livery
Box	atten atten I for u	iciar	in the past 12 months? 1 Veg. 2 Male	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month	Day Year
	the de by the achec	hys	9 Unknown				
P.0	requires that the been signed by the should be detach		Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.		acco use contribute to	Probably 4 Unknown
ds	equire een si ould 8	ted	-		24a, Was ar		stopsy findings available
S	law re has b e 2 st	Completed			autops perforr	ned? prior to death?	completion of cause of
R	sician: The law I certificate has b lirector, page 2 s	ပိ	25. Was case referred to medical	26. Place of Death (Chec	1 Yes 2	2 X No 1 □ Ye	s 2 🕱 No
/ita	sicia: certi	To Be	examiner?	Othor		nce 6 Other (Spec	cify)
of/	Attending Physician: or death. sctor: After this certific by the funeral director,	ië.	27. Manner of Death 28a. Date of injury 28b. T			w injury occurred	
o	endin sath. or: Aft	fical	2 Accident Investigation	M 1 Tes 2 No			
Division of Vital Records,	or Att fler de directo	Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, far building, etc. (Specify)	m, street, factory, office	28f. Location (Str City or Town	reet and Number or Ru , State)	ıral Route Number,
Ö	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	cal (29a. Certifier 1 Certifying Physician: To the best of my knowledge, of	leath occured at the time, date and place, a	nd due to the caus	se(s) and manner as st	ated.
	e Hos 124 h e Fun e Fun	Medical	(Check only one) 3 Certifying Nurse Practioner: To the basis of examination and/or	investigation, in my opinion, death occurred a	at the time, date an	d place, and due to the	cause(s) and manner stated.
	To the vithin To the comp	-	29b. Signature and title of certifier	29c. License number		9d. Date signed (Mon	
0			I hom I herd is a	02276	6	3/30/2	20/2
0			30. Name and address of person who completed cause of death (Item 23a) (I		sen Rd.	, Laurel,	MD. 20707
	Sta	to	Thomas H. Burguieres, MD Lau 31. Date filed (Month, Day, Year) 32. Registrar's Signature	rel Regional Hospit	ici, Eme	ergency	7
/	Registi		APR 0 3 2012 Senter S. A	arke			

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 1358 March John Williams Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Montgomery Washington Adventist Hospital Takoma Park If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Hours (Month, Day, Year) Director 571-36-7777 Usual Residence of Decedent 1 💢 M 2 🗆 F 7/27/1919 NC 92 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location notified at Director 28a-f DC Washington 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? iral", or items 23a o Examiner must be Funeral 20011 USA 121 Rittenhouse Street NW Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Xes 2 No 1942 If Yes, Give
Year or Dates. 1962 Black, White, etc. þ 1 Never Married 2X Married Maryland 21215-0036 1 Tes 2 X No Specify: Specify: Black "natural" Completed 3 Widowed 4 Divorced er than "natur , the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working United States Army life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) FEderal Government 9th Sargent of Health and Mental Hygie If item 27 is marked other or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Jessie Cheeks James Alexander Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Washington, DC 20011 it of Health a Vivian M. Williams/Wife 121 Rittenhouse St. NW altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 $\stackrel{\textstyle \mbox{\scriptsize M}}{=}$ Burial 2 \square Cremation 3 \square Removal from State cemetery, crematory or other place, Department o Important: If any injury or ō 4 Donation 5 Other (Specify) Quantico National 4/5/12 Triangle, VA 22. Name and Address of Facility Latimore Funeral Services Signature of Funeral Service L Baltimore, MD 2122 Baltimore St. 2818 E. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Du to (or as a consequence of) Exami the burial-trar Due to (or as a consequence of): resulting in death) Last nding physician Physician/Medical certificate be as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death signed by the at Id be detached for Yes 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? 2 No Yes filled in by the funeral director, To Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of icate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 🗌 No Accident Investigation 6 Could not be Certifi Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4

Homicide determined

Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: Twithin 24 hours after death.

To the Funeral Director: After this certifica

> State Registrar

Medical

29a. Certifier (Check

Date filed (Month)

APR 0

3

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar

Bassi

32. Registrar's Sichature

An isha Date filed (Month, Day, Year, Baltimore

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Joseph Waddell 2012March 31 11:34 A^M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 3357-A North Chatham Road Ellicott City Howard If Under 1 Year If Under 24 Hrs Months Days Hours Min. **Funeral** . Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year, 9. Birthplace (State or Foreign 213-22-3926 Director 1 ₹ M 2 □ F 85 Maryland Feb. 2, 1927 28a-f shov "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Howard 1 Yes 2X No Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3357-A North Chatham Road 21042 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian. Armed Forces? 1946-Black, White, etc. þ 1 Never Married 2 Married Yes Yes, Give Maryland 21215-0036 1 Yes 2 No Specify: White 1947 Completed 3

▼ Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Warehouse Worker General Electric Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Joseph P. Waddell Lorretta Dircks 19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 sl it of Health a: If item 27 is Carolyn Del Prete / In-Law 6007 Burnt Oak Rd., Catonsville, Maryland 21228 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 T Cremation 3 Removal from State 4 Donation 5 Other (Specify) ō permit. Page Department Important: If any injury or Metro Crematory Inc 04/02/2012 Baltimore, Maryland Signature of Euneral Service Licensee Alyson K Taylor 22. Name and Address of Facility Cremation Society of Maryland Inc 19 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician disease or condition resulting in death) 1546ac Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 the attending p IF FEMALE ase 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? 5 Other (specify) Day Pregnant at time of death Month Year 1 Yes 2 No ed by the a 9 Unknown Records, P.O. signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗷 Yes 2 🗆 No 3 🗆 Probably 4 🗀 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed cate 1 ☐ Yes 2 🕱 No 1 🗌 Yes 2 No Physician: • Hospital or Attending Physician: 24 hours after death. • Funeral Director: After this certific etely filled in by the funeral director, 25. Was case referred to medical examiner? Division of Vital Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 은 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 \(\sum \) Yes 1 X Natural 5 Pending Accident
Suicide Investigation 2 🗌 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou

To the Funel

completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) cutonsville 21238 MID uis In Mui Ca MD Frode 405 Suit 11 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2012 Physician/ John Denwood Windsor 28 March 11:15 A^M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Maryland Masonic Homes Cockeysville <u>Baltimore</u> Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Min. March 27, 1927 Norfolk, VA 214-22-3067 Director 85 Usual Residence of Decedent or 28a-f shov 10a. State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Baltimore Cockeysville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 300 International Cir. 21030 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. 1 Never Married 2 X Married Completed by 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give "natural", 3 Widowed 4 Divorced Specify: White Year or Dates. 45 -46 the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) should be mad and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 10 Pressman N/A Printing item 27 is marked other other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Denwood Windsor, Sr. Katie Emily Webster 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is Ellen L. Windsor/Wife 300 International Cir. Cockeysville, MD 21093 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) injury or Parkwood Cemetery $2\overline{0}1\overline{2}$ Parkville, MD 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley 10 W. Padonia Road Timonium, MD 21093 Signature of Funeral Ser icenses el J. FlagPe Part + Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) ears Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) that the death certificate be executed the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death Other (specify) Year 2 No the a 9 Unknown 9 Unknown ed by t detach s been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician: The law requires to within 24 hours after death.

To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be 1 Tyes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Yes 2 Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 🗌 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 1 🗮 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

State

parker

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

John W. Bowie, M.D.

APR 0 3 2012

31. Date filed (Month, Day, Year)

20649

300 International Circle, Cockeysville, MD 21030

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 17 ay 2012 11:00A March Dedria Williams Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Silver Spring Holy Cross Hospital 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Hours Min. 577-66-2218 Director 1 □ M 2 🗓 F Yrs 63 July 6,1948 Wash., DC Usual Residence of Decedent ns 23a or 28a-f show must be notified at 10a, State 10c. City, Town or Location the Maryland Director 1 X Yes 2 No DC Washington 10e. Street and Number 10g. Citizen of What Country? by Funeral 1512 Irving Street, N.E. USA 20017 or items permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Examiner Armed Forces Black White etc. 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify. If Yes Give Specify: 3 X Widowed 4 □ Divorced Black Completed Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b, Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Clerk Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 27 is marked of traumatic eve ဂ္ Parker Jeanette Clarence Paige 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Irving Street, NE, Wash., DC 20017 Important: If item 27 any injury or other tronce. Keith Washington/Son 1512 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ☐ Burial 2 X Cremation 3 ☐ Removal from State Chesapeake Crematory 3/28/12 Beltsville, MD Other (Specify) 4 Donation 22. Name and Address of Facility AUstin Royster Funeral Home u ral Service License 14th Street, NW, Wash., DC 3821 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Sepsis
Due to (or as a consequence of): Medical Examiner UTI Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause Disease or injury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and Tachycardia burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Failure to Thrive Division of Vital Records, P.O. Box 68760 as the k IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy ☐ Other (specify) ___ ó in the past 12 months?
1 Yes 2 X No Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pe 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Stroke page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 X 1 Yes 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify, Hospital 1 ☐ Yes 2X No မှ X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 2 No Certificate: 28d. Describe how injury occurred injury 1 X Natural 5 Pending Accident Investigation 6 Could not be

filled in by the funeral within 24 hou

To the Fune

completely fi the 2

m

Medical

Registrar

DHMH 17 Rev 06-2011

Garg,

determined

hama

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Suicide

29b. Signature and title of certifier

4 Homicide

29a. Certifier

(Check only one

Kshama

X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

D60826

,1500 Forest Glen Road, Silver Spring, MD

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number.

29d. Date signed (Month. Day, Year)

3/20/12

20910

City or Town, State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2012 Year 2:58 p^M CLARICE MARIE WHELCHEL March Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A1401 E. OLIVER ST. BALTIMORE Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Min (Month, Day, Year) **Director** 214-64-0351 1 □ M 2 XF Yrs 56 MAY 2 1955 MARYLAND Usual Residence of Decede or 28a-f show notified at 10b. County with the Maryland 10a. State 10c. City, Town or Location 10d, Inside City Limits Director 1 X Yes 2 □ No MARYLAND N/A BALTIMORE 10e, Street and Number 10f. Zip Code ō 10g. Citizen of What Country? ms 23a or must be r Funeral 1401 E. OLIVER ST. APT 409 21205 U.S.A. items 2 within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, "natural", or iten edical Examiner Armed Forces?

1 Yes 2 No Black, White, etc. 1 XNever Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: BLACK Completed 3 🗌 Widowed 4 🗌 Divorced permit. Page I and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature any injury or other traumatic event, the Medical once." Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) MAIL CLERK SOC SEC. ADMIN. 12th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ RUDOLPH WHELCHEL NINA MAE WHELCHEL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ricardo Whelchel/Son 511 Dennison St., Baltimore, Md., 21229 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY 04-3-2012 BALTIMORE, MARYLAND 21. Signature of Superal Service Licensee 22. Name and Address of Eacility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physitian/ >10415 disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-trar physician Physician/Medical or Attending Physician: The law requires that the death certificate be the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed page 2 this certificate 1 Yes 2 No Yes 2 No within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\mathbb{R} \) Residence \(6 \) Other (Specify) 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical

Division of Vital Records, P.O. Box 68760 Hospital

> State Registrar

29a. Certifier

29b. Signature

30. Name and

only one)

31. Date filed (Month, Day,

person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying-Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

York Rd, Steloo, hut

permit. Page 1 and 2 should be filed within 72 hours after death w. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items once. 09:05 am Physician **Examiner** 2muda, Robert J. march 30,2012 Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Funeral Director, After this certificate has been signed by the atte

For State Registrar 1. Decedent's f

4a. Facility Nam

Usual Resider

MD 10e. Street and

11. Marital State

17. Father's Na

Frank 19a. Informant Helen 20a. Method of 1 🗌 Buria 4 Dona

10a. State

Subul 5. Social Securi

Physician/

Medical

Examiner

Funeral Director

28a-f show

9

23a

Medical

attending physician and

signed by the

use as the

Examine

Physician/Medical

ckamine

23cd by modical Continuated by

reliasa

State Registrar

funeral director, page 2

must be notified at

Director

Funeral

þ

Completed

Be

မ

with the Maryland

	Plea		_							II Copies		gible.	
For State			State of M	arylar				Health Death	and N	nental Hygi	0	0.1.0	10000
Registrar Decedent's Name	e (First, Middle,	Last)			061	incat	COII	Death		2. Date of Death	eg. No.	UHZ	3. Time of Death
Robert		Jos	eph	Zmı	ıda					Month March	30	Year 2012	9:05 A ^M
Facility Name (if	not institution,					4b. City	, Town, c	or Location	of Death	1142011	4c. County		
	an Hosp	ital						thesd			M	ontgo	mery
Social Security N		6. Sex	1		ast birthday)	If Unde Months	r 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day,		9. Birth	olace (State or Foreign ltry)
206-14-1 Isual Residence		1 🔣	M 2 □ F	86	Yrs.					Jan. 21	,1926	Penr	sylvania
a. State	10b. County			10c. Cit	y, Town or Lo	cation							10d. Inside City Limits
MD	Mont	gome	ry			Be	thes	da					1 🗆 Yes 2 🔀 No
e. Street and Nun		_		-		10f. Zij	p Code			11	Og. Citizen of	What Coul	ntry?
4400 Eas	st West							.0814			Unite	d Sta	ites
Marital Status 12. Was Decedent Ever in U.S. Agried Forces? 1 □ Never Married 12. Was Decedent Ever in U.S. Agried Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Hyper Specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - America Black, White, etc.													
1 Never Married 2. Married 1. A. Yes 2 No If Yes, Give Year or Dates. W W II 1 Yes 2. No Specify: Specify: White										ite			
(Sne	15. Deceden	t's Educ	ation completed)		16a. Decec	dent's Usu	al Occup	pation during mos	t of work	ina	16b. Kind of E	lusiness/In	dustry
Elementary/Seco		1	College (1-4 or	5+)	life. Di	O NOT us	e retired,)			T2 1	-1 0	
Father's Name (First Middle 1:	as t)	4		FIE	ectri	caı	Engin		e (First, Middle, M			vernment
Frank		Murd	ock	Zmu	ıda				ice	e (First, Mildale, Mi	Wasil		
a. Informant's Na Helen Zn a. Method of Disp	nuda /			20b. F	4400	Eas	t We	st Hw	y. #	Al Route Number, G		MD	20814
1 Donation	Cremation 5 Other (Si	3 □ Re pecify)	moval from State		emetery, cren sapeak				04/0	2/2012	Be1t	svill	e, MD
Signature of Fu			moi	1	122 TR	Name a	Addre	ral a	hd C	remation ver Spri	Servi		20910
shock, or hea mediate Cause (rt failure. List o (Final	complica nly one o	ause on each lin	e.	-	er the mod	de of dyir	ng, such as	cardiac o	or respiratory arres	_		Approximate Interval Between Onset and Death 6 DAYS
sease or condition sulting in death)		T a.	Due to (or as	a conseq				ATHOL	OGIC	ALL			6 DAYS
any, leading to in luse. Enter Unde ause (Disease or at initiated event	nmediate rlying injury	Б.	Due to (or as		uence of): RENAL	DISE	ASE						3 YEARS
sulting in death) I		d.	Due to (or as	a conseq	uence of):								
FEMALE; b. Was decedent in the past 12 I 1 Yes 2 I 9 Unknown	months? ☐ No	230	. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 🗌 Feta	al death 3 L	Ectopic Other (s)		су			- 1	ate of deliv	ery Day Year
rt II. Other signif	ficant conditio		_	out not res	sulting in the u	ınderlying	cause g	iven in Part	1.				ne cause of death?
								_		24a. Was an autopsy perform	led?	Were auto prior to co death?	psy findings available mpletion of cause of
Was case referre	ed to medical						26. P	lace of Dea	th (Check		(NO	, 100	
1 X Yes 2	□ No	Hos	pital: 1 X Inpat	ient 2 🗆	ER/Outpatier	nt 3 🗆 D	Oth	ner: 4 🗌 Ni	ursing Ho	me 5 🗆 Resider	nce 6 🗆 Oth	er (Specify)
Manner of Death 1 X Natural 5 Pending (Month, Day, Year) 28a. Date of injury (Month, Day, Year) 28b. Time of injury work? 1 Yes 2 No 28c. Injury at work? 1 Yes 2 No													
3 ☐ Suicide 4 ☐ Homicide	6 Could r determi		28e. Place of Inj building, et			eet, factor	y, office			28f. Location (Stre City or Town,		er or Rura	Route Number,
0.40 1	V Cortifuing	Discontinui	T. 4b. b. 44 a.	man Lumman			4 4 5 - 41				o(a) and man	ner en etet	

21. Signature o 23a. Part 1. En shock, or Immediate Cal disease or con resulting in dea if any, leading to cause. Enter Up Cause (Disease that initiated eversulting in dear IF FEMALE: 23b. Was deced in the past 1 Yes 9 Unkn Part II. Other si PUL 25. Was case re 1 X Yes Manner of D 1X Natura
2 Accide
3 Suicide
4 Homici 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2 Li Medical Examiner: On the basis of examination and/or investigation, in my occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Li Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year, MARCH 30, 2012 D71517 CR 30. Name and address of person who completed cause of death (Item 29a) (Type, Print) 8600 OLD GEORGETOWN RD., BETHESDA, MD NATALIA VASQUEZ, M.D. 20817 32. Register's Significant ORIGINAL

19x

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 3 Physician/ lar Jane 10:30% 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Nusing 1411 arrias Montgomery <u>Bethesda</u> 6. Sex 7. Age (In vas. last birthday) If Under If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Hours Director 519-20-6927 1 M 2 M Jan. 2, 1925 Idaho Usual Residence of Decedent show 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at Funeral Director 28a-f MD Montgomery Chevy Chase 1 Yes 2 X No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? must be 23a 8100 Connecticut Ave. #1403 20815 United States filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Examiner Black, White, etc. ь 1 Never Married 2 Married 1 Yes 2 No
If Yes, Give
Year or Dates. Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify White Specify: "natural" Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) the 5+ Nurse Educator Medical Healthcare traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Lloyd Cox Windsor Emily 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important; If item 27 is any injury or other trau. Susan Zusy / Daughter 806 Gist Ave., Silver Spring, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 Burial 2 XCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory | 04/02/2012 Beltsville, MD 21. Signature of Funeral Service Licensee Name and Address of Facility
app Funeral and Cremation Services llice lser mg 1544 Gist Ave. 20910 Silver Spring. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final Onset and Death piratory Physician/ disease or condition Medical resulting in death) Leukem Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) nen attending physician and I for use as the burial-transi Due to (or as a consequence of) resulting in death) Last DOD-3/29/13, 10:30 pm Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Li retail use.
Pregnant at time of death 3 Ectopic pregnancy 5 Other (specify) ___ been signed by the atter in the past 12 months? Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed this certificate 2 🗌 No Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) al or Attending Pl s after death. 28c. Injury at 28b. Time of 28d. Describe how injury occurred Zusy 1 Natural 5 Pending work' 1 Yes 2 🗌 No Accident Investigation filled in by the Suicide Could not be Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined To the Hospital or within 24 hours a To the Funeral D Medical MARY JAHE 29a. Certifier Ceptifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. redical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 3 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mila Harding 10110 Molecular drive Rowulle Mila Harding 31. Date filed (Month, Day, Year 32. Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

3 2012

APR O

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 fems 1 per doc, 19a per th g926 4-12-12 vt

State of Maryland / Department of Health and Mental Hygiene 2 1 1 For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April Audrey Andersen-2012 8:00 PM Audrey Alma Andersen Medical Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Howard Brighton Gardens Columbia 6. Sex If Under 1 Year If Under 24 Hrs. Social Security Numbe Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Hours Min. (Month, Day, Year) **Director** 1 🗆 M 2 🗶 F 004-10-6512 97 October 15,1914 Maine Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at once. 10a, State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 Yes 2 No Florida 0sceola St. Cloud 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 2275 Darby Lane 34769 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2x No Specify: Specify: Completed 3 X Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Health Care Office Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Hannah Bugbee Greenleaf Lerov Clvde Williams 9a Informant's Name/Relationship (Type, Print) Frank Allan Andersen Allan Andersen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Son) Columbia, Maryland 21044 6236 Bright Plume 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) Atlantic Crematory 4-3-2012 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Witzke Funeral Homes, Inc. Columbia, Maryland 21045 SUI 5555 Twin Knolls Road 23a. Part 1. Enter the disease, or o perioditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final Physician/ Degenerative Disease of Lumbar Spine disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last use as the burial-tran and Due to (or as a consequence of) attending physician Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No for Year Month Day Pregnant at time of death detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be Division of Vital Records, Dementia 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Be Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No Debility 24a Was an autopsy performed? has page 2 certificate Yes 2X No director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner's ASSISTED Other: 4 Nursing Home 5 Residence 6 X Other (Specify) Living ျ 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA filled in by the funeral 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 2 No 27. Manner of Death Certificate: 28b. Time of 28d. Describe how injury occurred 24 hours after death. Funeral Director: After injury 1 X Natural 5 Pending Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the only one within To the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (N

D56531

Columbia, Maryland 21045

April 2, 2012

MD

2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Harry Li, 8600 Snowden River Parkway

APR 0°4 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	Glate Of Marylar	•	tificate of D			Reg. No.	0.1.0	
	Physicia		1. Decedent's Name (First, Middle, Las	Isaac Allen,	Sr			2. Date of Dea Month	ath 2 lar 30, 201	Year	3. Time of Death 3
	Medic Examir		4a. Facility Name (if not institution, give	street and number)	<u> </u>	4b. City, Town, or	Location of Death	-14		ty of Death	
	Funeral		5. Social Security Number 6. Se		ast birthday)	If Under 1 Year	Baltimore If Under 24 Hrs.	8. Date of Birt	:h	9. Birthpla	ice (State or Foreign
	Director		243-46-2992 Usual Residence of Decedent	X M 2 □ F 82	Yrs.	Months Days	Hours Min.	(Month, Da Feb	y, Year) 22, 1930	Country) NC
	yland •f show ed at	ctor	10a. State 10b. County		y, Town or Lo	cation	Dalliman			100	d. Inside City Limits
	the Mar or 28a e notifi	Director	MD Baltim 10e. Street and Number	ore City	 .	10f. Zip Code	Baltimore		10g. Citizen of	What Countr	1 Yes 2 No
	th with ms 23a must b	Funeral	3625 Ravenwood Aven		- I40 V		21213			USA	
9036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ρ	11. Marital Status 1 □ Never Married 2 ★ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.s Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates.		Vas Decedent of His f Yes, specify Cubar	spanic Origin? (Spen, Mexican, Puerto for Specify:	city Yes or No- Rican, etc.)		ce - American ack, White, etc y: Blac	o.
15-(72 hou In "natu Medica	Completed	15. Decedent's Ed (Specify only highest gra	de completed)	(Give I	lent's Usual Occupa ind of work done di O NOT use retired)	ation uring most of workin	ng	16b. Kind of I	Business Indu	stry
1212	d within lygiene. ther thant, the f	ادہ ا	Elementary/Seconday (0-12)	Callege (1-4 or 5+)	1170. 20		ployee		S	teel Con	npany
lanc	should be filed what and Mental Hyg r is marked other iraumatic event,	일	17. Father's Name (First, Middle, Last)	Peter Allen			18. Mother's Name		Maiden Surnan Alice L. Al	,	
Baltimore, Maryland 21215-0036	and 2 should Health and N tem 27 is ma other trauma		19a. Informant's Name/Relationship (Ty) Bernadette Allen	pe, Print)		g Address (Street a.	nd Number or Rural d Road, Ba		r, City or Town, MD 21213	State, Zip Co	de)
timore	Page 1 ar tment of H tant: If iter jury or oth		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State	emetery, crem	sition (Name of natory or other place Memorial Park	9)	o5, 2012	20c. Location	- City or Towi	
Bal	permit. Page Department Important: Il any injury or		21. Signature of Fineral Service License	Step .	22	Name and Addres. Estep Br 1300 Eut	s of Facility others Funera aw Place Balti	l Service, I more, Md 2	P. A. 21217		
-noch	Medical Examiner	Examiner	23a. Part 1. Enter the disease, or comp shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, learling to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	a. Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence)	ence of:	entra entra Hensia Les	g, such as cardiac of	respiratory arr	est,	lr	oproximate nterval Between nnset and Death
D. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Within 24 hours after death. The Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	d	ıl death 3 🗌	Ectopic pregnancy Other (specify)	y			ate of delivery onth Da	
ds, P.(requires that the de been signed by the should be detached	by	Part II. Other significant conditions co	ntributing to death but not res	ulting in the u	nderlying cause give	en in Part I.		res Mo		cause of death?
Records, P.O.	The law rec cate has bec page 2 sho	Completed						24a. Was a autop perfo	sy		findings available bletion of cause of
Vita	ysician is certifi director	To Be	25. Was case referred to medical examiner? 1 ☐ Yes No	lospital:	ER/Outpatien	Other	r: Nursing Hor		lence 6 🗆 Oth	ner (Specify)	
Division of Vital	ending Ph eath. or: After th he funeral	Certificate:	27 Manner of Death Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury work?	at 2		ow injury occur		
Divisi	ital or Attuirs after de al Directo led in by t		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify		et, factory, office	2	8f. Location (S City or Tow	treet and Numb n, State)	er or Rural Ro	oute Number,
	To the Hospital or Attending Physician: The Is within 24 hours after death. To the Funeral Director, After this certificate ha completed filled in by the funeral director, page	Medical	(Check 2 Medical Examin only one) 3 Certifying Nurse	cian: To the best of my knowl er: On the basis of examination Practioner: To the best of my	n and/or investi	gation, in my opinior eath occurred at the	n, death occurred at t time, date and place	the time, date a	nd place, and du	ue to the cause	
	To with		29b. Signature and title of certifier	LOAD O	שוגם	29c. License	number		29d. Date signe	d (Month, Da)	y, Year)
_			30. Name and address of person who co	empleted cause of death (Item	23a) (Type, P	rint) S	DA	D.11	9/31	mi	01771
	Stat	.6	31. Date filed (Month, Day, Year)	32. Registrar's Sign to	ure	J CME	is I'a,	Balti	more	ma.	21234
	Registra	ar	APR 0 4 2012 A	ma 1. 190	ale						

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 20b, per fh, g926 4-20-12 sm State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MARCH Bordle Marian 1315KM ,2012 Medical Facility Name (if not institution, give street and number 4c. County of Death 4b. City, Town, or Location of Death Examiner Dimai Battinone Baltimore HOSPITAL 01 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, 215.28.2777 **Director** 1 □ M 2 💢 F 82 MD a Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits death with the Maryland notified at Director MD Baltimore Windsor Mill 1 Yes 2 XNo Bordler 10e. Street and Number ò 10g. Citizen of What Country? ritems 23a or ner must be n Funeral 21244 7511 Lexham USA Caurt 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. 11. Marital Status er than "natural", or ite the Medical Examiner Armed Forces?

1 Yes 2 No þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Black Completed 3 Divorced Marion 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Education Teacher 5+ vears Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Bennie Maranje Brown Hester 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 92 7511 Lexham Court Windsor Mill, MD 21244 Tinley A. Bordley (Husband) Department of Healt Important: If item 2 any injury or other t 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 4/23/12^{ate} SALL SALL 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Duings Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest C. Greene Funeral Services 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Vallann Vau 8728 Libert Road Randallstown MD patient 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myocardial Physician/ Acute Medical Due to (or as a consequence of **Examiner** nel 050 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) Month Year Pregnant at time of death been signed by the a should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? To Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy this certificate has filled in by the funeral director, page 2 2 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 No 1 Yes ER/Outpatient 3 DOA 1 Inpatient 2 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Mann of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Medical Certificate: 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After 5 Pending injury 1 V Natural Accident Investigation 6 Could not be Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signatu 29c. License number 29d. Date signed (Month, Day, Year) 31,2012 ess of person who completed cause of death (Item 23a) (Type, Print) Sinci H 30. Name and address of p 2 Balti more 0

DHMH 17 Rev 06-2011

State

Registrar

APR 0 4 2012

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1 - State Amend Item 21 per fh,g926,04/04/2012dhb,24a,26 per verbal Certificate of Death

Reg. No. Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2308 Month Physician/ ANN GICICIA 20 Medical Facility Name (if not institution, give street and number) County of Death Examiner 4b. City, Town, or Location of Death Prince helen Communiti If Under 24 Hrs. 9. Birthplace (St. 7. Age (In yrs. last birthday) If Under 8. Date of Birth **Funeral** Min **Director** 1 M 2 F WASh. 15 0 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits aţ Director Medical Examiner must be notified WD ANDOVER 1 ₩es 2 No 10e. Street and Number 0 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 2078 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married o, þ Maryland 21215-0036 filed within 72 hours after Yes 2 1 Yes 2 No Specify: If Yes, Give Year or Dates 3 ₩idowed 4 Divorced BlAck "natural", Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working (Give kind of work done life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) the or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ UNKNOW Page 1 and 2 should be 19a. Informant's Name/Relationship (Type, Print, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important; If Item 27 is any injury or other trau 2782 Cotton bid ne ct Monigoe succuer Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State crematory or other place Belteville, MD 3/20/2012 4 Donation 5 Other (Specify) Paul Al Mateen 22. Name and Address 20002 per DVR 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death such as cardiac or respiratory arrest, Immediate Cause (Final Providen/ Disse minuted atrasculur Coogniation disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Metostatic panicrentle rancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine for use as the burial-transi and Due to (or as a consequence of) attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the at Id be detached for 1 Yes 2 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? To Be Completed by Respiratory acluve 1 Yes 2 No 3 Probably 4 Unknown should peen Alcoho) Were autopsy findings available prior to completion of cause of death?
 □ Yes 2 □ No Chronic ahuse 24a Was an autopsy performed? Yes 2 X No has page 2 nepatitis 24 hours after death.

Funeral Director; After this certificate completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 Yes 2 No 1X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Medical Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide determined 🗜 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 662 604 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 06-2011

State

NILhAU

31. Date filed (Month,

Gi Ho

. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

tudolph Best, J	r	State of Maryland Registrar	/ Department of Certificate of	f Health and Mental H FDeath	lygiene Reg.	No. 2012	2 1033
Physici Medical Exami		1. Decedent's Name (First, Middle, Last) Rudolph Best	Jr		2. Date of Death Month D March 29, 20	Pay Year 012	3. Time of Death 0737 hrs
		 Facility Name (if not institution, give street and number) 9302 Vaughn Place)	4b. City, Town, or Location of Deat Lanham	n	4c. County of Death Prince George	
Funeral Director			ge (In yrs. last birthday)	If Under 1 Year If Under 24Hr Months Days Hours Min		MM/DD/YYYY) 9. Birth	n Do
Director		2/3-15-188-5 1 1 M 2 F Usual Residence of Decedent	34 Yrs.		Jan 23	3, 1478 COL	intry) DC
nd how any cc.	_	10a. State 10b. County Drince Georges	10c. City, Town or Locati				10d. Inside City Limits 1 Ves 2 No
Maryland r 28a-f show	Director	10e. Street and Number)i	10f. Zip Code	10g.	Citizen of What Coun	try?
death with the Maryland or items 23s or 28s-f sho must be notified at once.	-	1302 Vaughn t		s Decedent of Hispanic Origin? (S	pecify Yes or No-	14. Race - Americ	can Indian, Black,
- · I	Funera	1 Never Married 2 Married Armed Forces? 1 Yes 2 3 Widowed 4 Divorced If Yes, Give Year	No	es, specify Cuban, Mexican, Puerto Yes 2 No specify:	Rican, etc.)	White, etc.	lock.
hours aft natural" 'xamine	ed by	15. Decedent's Education (Specify only highest grade con	npleted) 16a. Deceden	t's Usual Occupation (Give kind of ost of working life, DO NOT use ref		Sb. Kind of Business/Ir	ndustry
036 ithin 72 t ne. r than "1	Completed	Elementary/Secondary (0-12) College (1-4 or s	5+)	elivery	(Crosby	Caro
10re, MD 21215-0036 ges I and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. t: If item 27 is marked other than "natural", or items 23a or 28a-f sho other transmatic event, the Madical Examiner must be notified at once	Be Cor	7. Father's Name (First, Middle, Last) Rudoton Best	32		e (First, Middle, Mai	den Surname)	
D 212 should be and Ment is mark	To E	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing	Address (Street and Number or	1	r, City or Town, State,	11
- P = = =	100	20a. Method of Disposition		Vaughn +	Date 2	Oc. Locetion - City or T	MD 20706 Fown, State
		1 ✓ Burial 2 Cremation 3 Removal from Sta 4 □ Tonation 5 Other Specify:	Lincoln	Memoual 4	6/2012	Buitlanu	d, MD
Baltimo permit. Pag Department Important: injury or or		Signat & Funeral Se vinc Licensee	22. N	ame and Address of Facility	THE RO	Eunera 1005lus	Home
Physician /Medical		i. Infer the list se, or complications that caused failure. List only one cause on each line.		ne mode of dying, such as cardiac	or respiratory arrest,	shock, or heart	Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Cardiomeg Due to (or as a conse					Deati
	miner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause	equence of):				
Couted and transit	Exami	(Disease or injury that initiated events resulting in death) Lest C. Due to (or as a conse	equence of):				10-e1
a a	dical	d. ☐ AMENDED ☐ AMENDED 23a,	,pt.II,27,pe	r me,g927 5-2-12	2 sm		· - 4
8760, iificate be ng physici	š	F FEMALE: 23c. If yes, outcon 1 Live birth		al death 3 Ectopic pregna	ancy	23d. Date of delivery Month Da	av Year
Box 6876(c) death certificate is the attending physical for use as the b	ysicia	past 12 months? 1 Yes 2 No 9 Unknown 9 Unknown	time of death	ner (Specify)			
res that the de signed by the be detached f	by Physic	Part II. Other significant conditions contributing to death	h but not resulting in the u	nderlying cause given in Part I.		cco use contribute to the	ne cause of death?
of Vital Records, P.O. ng Physician: The law requires that it there this certificate has been signed by meral director, page 2 should be detac	eted	Obesity			24a. Was an	24b. Were auto	opsy findings available
Recol The law cate has	Completed				autopsy performe 1 ✔ Yes 2	d? death?	empletion of cause of
Vital Rec ysician: The l his certificate l director, page	8	25. Was case referred to medical examiner? Hospital: 1 Inpatie	ent 2 ER/Outpatient	26.Place of Death (Check 3 DOA Other4 Nursin		sidence 6 🗸 Other:	Scene
~ ■ . ~ ≥ l	91: To	27. Manner of Death 28a, Date of Inju (Month, Day,Yo	ıry 28b. Time of In	njury 28c. Injury at Work?	28d. Describe how		
Division tal or Attendit s after death. a) Director: A	Certification:	2 Accident Investigation	jury - At home, farm, stree	1 Yes 2 No		et and Number or Rura	al Route Number, City
DIV ospital or hours afte uneral Dir ly filled in		4 Homicide determined (Specify)		30	or Town, State		
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only prescripting Physician: To the best of my pres) 2 Medical Examiner: On the basis of examiner and manner stated.					
	Ž	296. Signature and title of certifier	7	29c. License number O.C.M.E.		ed. Date signed <i>(Mont</i> March 30, 2012	th, Day, Year)
1	}	30. Name and address of person who completed cause of de					
Ψ st	ate	31. Date filed (Month, Day, Year) 32. Registrar	r's Signature	altimore Street, Baltimore,	MD 21223		
Regist		ADD 0 4 2012 Pareles A.	Marke				

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, 2. Date of Death Month 3. Time of Death Physician/ Bla nard 20 Tenning 100 av Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death lumbia _0 to was 7. Age (In yrs. last birthday 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth **™** M 2 □ F Months Hours Min. Oct 18. Director 80 Maryland 213-28-1723 Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Framinar must be accided as 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 X No Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10 Forest Drive 21228 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 No Black, White, etc þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify White If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) <u>Insurance Executive</u> Insurance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Edward Thomas Blake, Sr. Ella Tomasia Bidgood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas Blake Son Park Drive; Catonsville, MD 21228 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State Loudon Park Cemetery 4 Donation 5 Other (Specify) 4-3-2012 Baltimore, Maryland 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 Name and Address of Facility Signature of Puneral Service Licen Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ espirator ndrome disease or condition resulting in death) Medical or as a consequence of Examiner Securificativ list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of Exam Hospital or Attending Physician: The law requires that the death certificate be executed nte attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 No ed by the a 1 Yes 2 L 9 Unknown s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an is certificate has director, page 2 : 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 P No Hospital: Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this in by the funeral 27. Manne of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural iniury 5 Pending s after death ☐ Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours aft

To the Funeral Di

completed filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signatur and title of of tifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jalv filed (Month, Day, Year) State 4

DHMH 17 Rev 7/2009

Registrar

12-02560 Ryan Bailey

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

kyan Balley	State of Maryland / Department 1- For State Registrar Certificate	of Death R	2012 1034					
Physician/ Medical Examiner		2. Cate of Dea Month March 31						
	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Oeath	4c. County of Death					
Funeral	York Road at Washington Avenue 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Towson If Under 1 Year If Under 24Hrs. 8. Date of Bit	Baltimore County inth(MM/DD/YYYY) 9. Birthplace (State or					
Director	052-80-6932 _{1→M 2} 20	44 11 10 141	3/1991 Foreign New Country) York					
w any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loc 10c. City, Town or Loc		10d. Inside City Limits 1 Yes 2 No					
the Maryland is or 28a-f show utified at once. Director	New York Hempstead Seaford 10e. Street and Number		10g. Citizen of What Country?					
with the Maryland ms 23a or 28a-f sho be notified at once, eral Director	3847 Voorhis Lane	11783	U.S.A.					
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once To Be Completed by Furneral Director		Was Decedent of Hispanic Origin? (Specify Yes or No f Yes, specify Cuban, Mexican, Puerto Rican, etc.) Yes 27 No specify:	o- 14. Race - American Indian, Black, White, etc. Specify: White					
hours a	15. Decedent's Education (Specify only highest grade completed) 16a. Decedenting College (1.4 or 54)	lent's Usual Occupation (Give kind of work done most of working life. DO NOT use retired)	16b. Kind of Business/Industry					
5-0036 ed within 72 hours by givene. other than "natu the Medical Exam Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 3 St	udent	Education					
MD 21215-0036 12 should be filed within 7 th and Mental Hygiene. 127 is marked other than numatic event, the Medica To Be Comple	William P. Bailey	18.Mother's Name (First, Middle, Susan D. Kuhn	-					
AD 21 2 should 1 and Mer 27 is man matic ev	19a. Informant's Name/Relationship (Type, Print) Susan D. Bailey 3847	ling Address (Street and Number or Rural Route Nur Voorhis Lane Seaford, N						
ore, Nest and of Health If item	20a. Method of Disposition 20b. Place of Disposition crematory or	position (Name of cemetery, Date	20c. Location - City or Town, State Westberry, New York					
Baltimore, pernit, Pages I ar Department of Her Important: If ite injury or other tr	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	Name and Address of Facility Marzullo	Funeral Chapel, P.A.					
M 립스크로 Physician	23a. Part I. Enter the disease, or complications that caused the death. Oo not enter	009 Harford Road Baltimo						
Medical xaminer	failure. List only one cause on each line. Immediate Cause (Final disease a, Multiple Injuries		Between Onset and Death					
	or condition resulting in death) Oue to (or as a consequence of): Sequentially list conditions, b.							
niner								
50, te be executed ysician and e-bucial - transit	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.							
50, te be executed sysician and broad - transit	UNPENDED AMENDED							
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi edical Certification: To Be Completed by Physician/Medical Ei		Fetal death 3 Ectopic pregnancy Other (Specify)	23d. Date of delivery Month Day Year					
P.O. B ss that the d igned by the or detached I by Phy			obacco use contribute to the cause of death? s 2 V No 3 Probably 4 Unknown					
rds, Frequires been sign hould be		24a. Was	an 24b. Were autopsy findings available					
Records, The law requires ficate has been sign, page 2 should be Completed			ormed? death?					
ital Recition: The sertificate rector, page	25. Was case referred to medical examiner? Hospital:	26.Place of Death (Check only one) ent 3 DOA Other Mursing Home 5	Posidence 6 Other Scope					
Division of Vital Records, na or Attending Physician: The law requirers after death. 11 Director: After this certificate has been siled in by the funeral director, page 2 should be ortification: To Be Completed	1 Yes 2 No 28a Date of Injury 28b Time of	of Injury 28c. Injury at Work? 28d. Describe	how injury occurred struck by auto					
Division of spiral or Attending nours after death. Tilled in by the function: After function of the function o	Accident Suicide Suicide Suicide Pending Investigation Investigation Suicide S	reet, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City					
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	State) Washington Avenue, Towson, MD							
29a. Certifier (Check only one) 2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Montre								
T S	29b. Signature and title of certifier	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) March 31, 2012					
30. Name and address of person who completed cause of death (Item 23a)								
% √ State	Ling Li, MD Assistant Medical Examiner 900 W. Baltim 31. Date filed (Month Pay Year) 32. Legistrar's Signatur							
Registrar	11 11 11 11 11 11 1 11 1 11 1 11 11 11							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April 2012 10:55 A M William Shannon Berry Medical 4a. Facility Name (if not institution, give street and number) 4b. City Town, or Location of Death 4c. County of Death Examiner Calvert Huntingtown 651 Walton Road If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth 6. Sex Social Security Number **Funeral** 1 M 2 □ F Days Hours Min ^{(M}051 P21 Y560 Washington 51 535-50-3092 Director Yrs Usual Residence of Deceder 28a-f show 10d. Inside City Limits 10h County 10c. City, Town or Location 10a. State the Maryland at Director be notified 1X Yes 2 □ No Huntingtown Calvert MD 10f. Zip Code 10g. Citizen of What Country? 23a or 2 10e Street and Number Funeral must I **USA** 20639 651 Walton Road items within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Examiner was becedent Ever in U.S.
Armed Forces?

1 X Yes 2 \sum No Navy
If Yes, Give
Year or Dates. or þ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: Specify "natural", White 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) than, Elementary/Secondary (0-12) College (1-4 or 5+) Federal Government Research Engineer 2 should be filed with h and Mental Hygien 7 is marked other tl 12 traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Carla Sabins William Berry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health at Important: If item 27 is any injury or Attach 651 Walton Road, Huntingtown, MD 20639 Kathleen Ruth Berry / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State 04.04.2012 Beltsville, MD Chesapeake Crematory 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 Dorota Marshall 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Cancer Meinstatic disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Embolin ulmonas Sequentially list conditions Examine if any, leading to immedicause. Enter Underlying the burial-transit Cause (Disease or injury that initiated events resulting in death) Last that the death certificate be executed Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as ding IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Other (specify) Pregnant at time of death signed by the at I be detached for Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has sompletely filled in by the funeral director, page 2 sompletely filled in by the funeral director, page 2 sompletely filled in by the funeral director, page 2 sompletely filled in by the funeral director. autopsy performed 1 ☐ Yes 2 ☑ No Yes 2 N 26. Place of Death (Check only one) or Attending Physician: 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify <u>_</u> 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 50290

State Registrar

DHMH 17 Rev 06-2011

Dhireh 31. Date filed (Month, Day, Year)

APR 0 4 2012

RD

HOSP

Trinu

MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

130

32. Registrar's Signature

2

00678

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 For State Registrar Certificate of Death Rea. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Deborah Ann Bence March 2012 08:02am Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🗀 F Months (Month/13/1932 216-68-9240 59 Pennsylvania Director Usual Residence of Decedent 28a-f show ms 23a or 28a-f sho must be notified at 10a. State 10c. City, Town or Location Director 10d. Inside City Limits MD 1 Yes 2 No Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12716 Eldride Place 20906 USA 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner 1 X Never Married 2 Married Black, White, etc. ō ş within 72 hours after Maryland 21215-0036 1 ☐ Yes 2X No Specify: "natural", 3 Widowed 4 Divorced Completed White Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4 or 5+) the should be filed with and Mental Hygien. Did Not Work 5 N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Bence Joanne May 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a Cheryl Lynn Yoezle / Sister 9291 Windsor Drive, La Plata, MD 20646 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Page 1 1 Burial 2 Cremation 3 Removal from State injury or permit. Page Department c Important: If any injury or 4 Donation 5 Other (Specify) Chesapeake Crematory 3/31/2012 Beltsville, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Myocardial Infarction Onset and Death Physician disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Diabetes Mellitus Sequentially list conditions, if anv. leading to immediate cause. Enter Underlying Due to (or as a consequence of Exami Hyperlipidema that the death certificate be executed Cause (Disease or injury that initiated events sician and burial-tran Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Box 68760 as the attending IF FEMALE use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy for in the past 12 months? Pregnant at time of death Other (specify) Month Day Yes 2 No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ e, Division of Vital Records, Hospital or Attending Physician: The law requires Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? page certificate 1 Ves 2 No Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No ၉ X □ ER/Outpa<u>tient 3 □ DOA</u> 1 Inpatient 2 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 27. Magner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 □ Yes Certificate: 28d. Describe how injury occurred Natural 5 Pending within 24 hours after death To the Funeral Director, A 2 🗌 No Investigation 6 Could not be Accident Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely the only one) 3 29b. Signatu title of certifier 29d. Date signed (Month, Day, Year)

Bay

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

Nnenna I. Okigbo, M.D. 11161 New Hampshire Ave., Silver Spring, MD 20904

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D60824

March 29, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month ROGER CARL BAYLY 0 26 201 4:33 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 526 Sunset Knoll Arundel Pasadena Anne Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth 1 XM 2 🗆 F Months Days Hours 8/15/1939 219 72 Director 26 6670 MD Usual Residence of Decedent ms 23a or 28a-f show must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any pince. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** Anne Arundel Pasadena 1 Yes 2 No MD 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 526 Sunset Knoll Rd 21122 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify Specify: 3 X Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10 Pipe Insulator Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Oscar L. Bayly Margaret L. Harthanski 19a. Informant's Name/Relationship (Type, Print) Signif. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 526 Sunset Knoll Rd Patricia Kwiecinski - Öther Pasadena, MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/27/12 Baltimore, Bayview Crematory 22. Name and Address of Facility GJ Gonce Funeral Home 21. Signature of Fundal Service Licensee PA 21122 169 Riviera Drive Pasadena, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Se mentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): attending physician and for use as the burial-translt Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bur Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year 5 Other (specify) Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably Wunknown Be Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 1 Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 21 No 2 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 8c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 2 Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature an title of certifie 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) 21 alen Burnie, MD 210ce State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #20b Per FH G926 4/04/2012 JH. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. edent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2012 8:40 PM oears Medical 4a. Facility Name (if not institution, give street and Town, or Location of Death **Examiner** 4c. County of Death Sinon Hospital rultimore Jaltimore 5. Social Security Number Year If Under 24 Hrs. 6. Sex Age (In yrs. last birthday) 8 Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 1 Hours (Month, Country) MD 217-62-1699 Director Usual Residence of Decedent 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City imits **Funeral Director** ms 23a or 28a-f s must be notified MD 1 Yes 2 No timore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? , or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in US Armed Forces? 11. Marital Status 14. Bace - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify "natural", 3 Divorced 4 Divorced Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO (TS) use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) ocia Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, SB မ Informant's Name/Relationship (Type, Print) KIDWI State, Zip Code) MD ronp 21215 tusband 20a Method of Disposition Place of Disposition (Name Liquid Ongale of St. 20c. Location - Ci ☑Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5-2012 imore, MI) Patient 21. Signature of Funeral Service License Funeral Services 23a. Part 1. Enforthe disease, or complications that caused the death. Do not enter the mode of dying, such as carefact shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final of Physician omplications disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be a within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia completed filled in by the funeral director, page 2 should be detached for use as the burn completed filled in by the funeral director, page 2 should be detached for use as the burn Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Pregnant at time of death Year 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. iis ceruilcate has been signed li director, page 2 should be det 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 1 No 1 Yes 2 UN To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 5 \square Pending injury Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 10054482 March 29, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) of Baltimore McGin 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2012 Registrar ADD () 4

12-02521 Debra Renee C		1- For State Certific.		ygiene	gible. 2012 1034
Physici Medical Exam	an/	1. Decedent's Name (First, Middle, Last) Debra Renee Chatelain		2. Date of Death Month March 29,	h 3. Time of Death
Medical Exam	IIIGI	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Deatl		4c. County of Death
Function		Southern Maryland Hospital 5. Social Security Number 6. Sex 7. Age (In.yrs. last birt	Clinton If Under 1 Year If Under 24Hr.	B Date of Birth	Prince George's th(MM/DD/YYYY) 9. Birthplace (State or
Funeral Director		5. Social Security Number 578-74-1173 6. Sex 1. M 2 F 7. Age (In yrs. last birth 1. M 2 F F 7. Age (In yrs. last birth 1. M 2 F F F F F F F F F F F F F F F F F F	Yrs. Months Days Hours Min		56 ForeignWash.D C
te Maryland or 28a-f show any fied at once,	tor	10a. State MD PG 10c. City, Town Suit1	and		10d. Inside City Limits 1 Yes 2 XNo
he Mary or 28a- ified at	Director	3859 St. Barnabas Rd-T3	10f. Zip Code 20746	10	0g. Citizen of What Country? USA
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland hand Mental Hygiene. 27 is marked other than "natural", or items 23s or 28s-f shown after event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced of Dates: 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 1/5 No.	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerto 1 Yes 2 No specify:		14. Race - American Indian, Black, White, etc. African Specify: Amer.
nore, MD 21215-0036 sees I and 2 should be filed within 72 hours after not Health and Mental Hygiens in the If item 27 is marked other than "natural", other traumatic event, the <u>Medical Examiner.</u>	Completed t	15. Decedent's Education (Specify only highest grade completed) 16a. I Elementary/Secondary (0-12) College (1-4 or 5+)	Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use ret Customer Svs Rep		16b. Kind of Business/Industry PUT
MD 21215-0036 d. 2 should be filed within 7 th and Mental Hygiens a 77 is marked other than rumatic event, the <u>Medica</u>	Be	17. Father's Name (First, Middle, Last) James A. Williams	18.Mother's Name Dorothy	Cross	en
MD 2 2 should h and M 27 is m	٩	19a. Informant's Name/Relationship (Type, Print) Terrance Wiliiams/Son	Mailing Address (Street and Number or 1722-28th St.SE, W	Rural Route Numl Nash. D	ber, City or Town, State, Zip Code) C 20020
Baltimore, Nermit. Pages I and Department of Healtl Important: If item injnry or other trav		1 Burial 2 Cremation 3 Removal from State River	dale Pk Crem.		20c. Location - City or Town, State Riverdale, MD
Baltimo permit. Page Department Important:	8	21. Signature of Funeral Price Lives	22 Name and Address of FacilityHar 5126 Belair Rd,	i P. C. Balt.,	lose F.Svs,PA MD 21206-5105
Physician /Medical Examiner	er	23a. Part I. Inter the disease, or complications that caused the death. Do no failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate a. Intracerebral Hemorrhage Due to (or as a consequence of): Hypertensive Cardiovascular of the death of th		or respiratory arre	st, shock, or heart Approximate Interval Between Onset and Death
cuted transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.			
exe ian a	dica	☐ UNPENDED ▼ AMENDED # 1 as noted	per me,g926 4-23-12	2 sm	
Division of Vital Records, P.O. Box 68760, Carlor of Attending Physician: The law requires that the death certificate be executed that clean. 1 Director: After this certificate has been signed by the attending physician and led in by the funeral director, page 2 should be detached for use as the burial - tran		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 ✓ Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 4 Pregnant at time of death 5		ancy	23d. Date of delivery Month Day Year
P.O. E res that the c signed by the be detached	<u>a</u>	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.	23e. Did tob	pacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown
Division of Vital Records, P.O. Box To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attended by the funeral director, page 2 should be detached for the completely filled in by the funeral director, page 2 should be detached for the funeral director.	Completed			24a. Was ar autops perform 1 🗸 Yes 2	prior to completion of cause of med?
Vital ysician: his certi	o Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Out	26.Place of Death (Check otpatient 3 DOA Other Nursin		Residence 6 Other:
	⊢ ⊦	27. Manner of Death 1 V Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. 1	ime of Injury 28c. Injury at Work? 1 Yes 2 No	2Bd. Describe ho	ow injury occurred
Division of To the Hospital or Attending Phwithin 24 hours after death. To the Puneral Director: After tompletely filled in by the funeral	Certification:	Suicide Could not be determined (Specify)	rm, street, factory, office building, etc.	28f. Location (St or Town, Sta	treet and Number or Rural Route Number, City ate)
To the Hos within 24 h To the Fun completely	Medical	29a. Certifier (Check only one) 2 Medical Examiner: On the best of my knowledge, deal one)			
To with	Mec	29b. Signature and title of certifier	29c. License number	· · ·	29d. Date signed (Month, Day, Year)
5	-	Name and address of person who completed cause of death (Item 23a)	O.C.M.E.		March 30, 2012
			900 W. Baltimore Street, Balti	more, MD 21	223
St Regis	ate	31. Date filed (Month, Day, Year) APR 0 4 2012 32. Registry's Signature	1		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 12-02514 State of Maryland / Department of Health and Mental Hygiene Augustine Joseph Cerminara 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month 1014 hrs CERMINARA March 29, 2012 AUGUSTINE JOSEPH **Medical Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Wicomico Peninsula Regional Medical Center Salisbury 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 6 Sex 5 Social Security Number Funeral Days Months Hours 07/07/1956 Director Country)DELAWARE 221 46 0145 55 1X M 2 F Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c, City, Town or Location 10a State 1 Yes 2 X No KENT SMYRNA DE 23a or 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygienc.

Tant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once. Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 19977 USA 135 FIELDS DRIVE uneral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces 2 X Married 1 Never Married 2 X No Yes Specify: WHITE f Yes, Give Year 1 Yes 2 No specify: 3 Widowed 4 Divorced <u>6</u> 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 CONSTRUCTION 12 0 MASON 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) AUGUSTINE CERMINARA CARMELA RIZZO Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) DELAWARE 19977 CYNTHIA K. CERMINARA/WIFE 135 FIELDS DR. SMYRNA, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 Burial 2 Cremation 3 X Removal from State CENTURY CREMATORY 4/6/12 WILMINGTON, DE Donation 5 Other Specify: 22. Name and Address of FacilityCVACH/ROSEDALE FUNERAL HOME 21. Signature of Funeral Ser ice Licensee 1211 CHESACO AVE BALTIMORE, MD 21237 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death a. Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed tending physician and use as the burial - tran Physician/Medical UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Month Day Live birth Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown signed by the a I be detached fo 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 V Unknown <u>6</u> Completed 24b. Were autopsy findings available 24a. Was an certificate has been prior to completion of cause of autopsy performed? ✓ Yes 2 No 1 Yes 2 No page 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 Inpatient 2 🗹 ER/Outpatient 3 🗌 DOA Other Nursing Home 5 Residence 6 Other: this 1 🗸 Yes 2 No 28a. Date of Injury (Month, Day,Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 27. Manner of Death Certification 1 V Natural 1 Yes 2 No 5 Pending Director: 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. within 24 hours after To the Funeral Dire 3 | | Could not be Suicide or Town, State) determined (Specify) Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier March 30, 2012 O.C.M.E allan aral 30. Name and address of person who completed cause of death (Item 23a) 900 W. Baltimore Street, Baltimore, MD 21223 Assistant Medical Examiner Carol Allan, MD

DHMH 17 Rev 1/2001 OCME 2006

State Registrar

OCME

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2115 201 Medical Facility Name (if not institution, give street and number) City, Town, or Location of Death Examiner 4c. County of Death HOPKINS Sex 1 M 2 F Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 Virginia If Under 24 Hrs. Date of Birth **Funeral** Min ^{(M}67/1017/1954 57 **Director** 28a-f show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director notified Yes 2 No VA Loudoun Sterling 10e. Street and Number 10f. Zip Code ŏ 10g. Citizen of What Country? ms 23a or must be r Funeral 20755 Ouiet Brook Place 20165 USA death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examir Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify Specify Completed 3 Widowed 4 X Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Engineer Telecommunications Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ John Carr Unkn. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Archie Norford / POA 7430 Little Chatterton Lane, King George, VA 22485 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4/3/2012 4 Donation 5 Other (Specify) Chesapeake Crematory Beltsville, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Dorota Marshall 1 Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ PERITONITIS disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner CIRRHOSIS Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-trai Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Live Fetal Go.
Pregnant at time of death 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Vear signed by the at id be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ OSSTAUCTION ACUTE NENT L FAILURE 1 Tes 2 No 3 Probably 4 Unknown Completed plnous peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy performed this certificate 1 Yes • Hospital or Attending Physician: 24 hours after death. • Funeral Director: After this certifica funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Yes 2 X No ည 1
Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation completely filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) . Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🙇 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check To the Within 2 3 🗌 only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) RES-000 3/30/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 N. Wolfe St. Baltimore, MD 21287 0

State

Registrar

31. Date filed (Month, Day, Year,

2012

32. Registrar's Signature

DHMH 17 Rev 7/2009

12-02195

Fareed Rashawn Caldwell

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

TAbe of Little Die	ick inachbie inik	Lilouis / til ot	P.00
State of Maryland /	Department of He	ealth and Menta	al Hygiene

2	\cap	1	2	1	0	2	1	0
C.	U	- E	6	-	U	J	4	J

areeu Nasilawi	1	Certificate of Death		eg. No.	2 1004
Physicia Medical Examin	ın/	1. Decedent's Name (First, Middle,Last) FAREED RASHAWN CALDWELL	2. Date of Dea Month March 16,	Dav Year	3. Time of Death 2338 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Sinal Hospital Baltimore		4c. County of Deat	
Funeral Director		213-13-7417 1XM 2F 25 Yrs. Months Days Hours Min		th(MM/DD/YYYY) 9. Bi Forei -1986	rthplace (State or gn ountry) MARYLAND
м ану		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits 1 Yes 2 No
with the Maryland ns 23a nr 28a-f shnw be notified at once.	Director	MD • N/A BALTIMORE 10e. Street and Number 10f. Zip Code		0g. Citizen of What Cou	11
ith the M 23a nr 2		3049 W. SPAULDING AVE. 21215 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S	pecify Yes or No	USA 14. Race - Ame	rican Indian, Black,
after death	by Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto 1 Yes 2 No If Yes, Sive Year or Dates: If Yes 2 No specify:	o Rican, etc.)	White, etc.	ACK
5-0036 led within 72 hours Hygiene. other than "natur the Medical Exami	leted	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) -120- MECHANIC		AUTO	maustry
15-003(filed within Hygiene. d other that,	Completed	17. Father's Name (First, Middle, Last) 18. Mother's Name		Maiden Surname)	
	Be	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or	IA CAMP: Rural Route Nur	mber, City or Town, Stat	e, Zip Code)
≥ 5 d = 1		MALIK CALDWELL (BROTHER) 28 ENCHANTED HILLS 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	RD. APT	I BALTIMOR 20c. Location - City o	
Baltimore, permit. Pages I as Department of He Important: If ite		1 Burial 2 K Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: METRO CREMATORY 3— 21. Significance of Funeral Service Licensee DORETHA HECTOR 22. Name and Address of Facility PHI	28-2012	BALTIMORE	MARYLAND
M ឱ្យជាផ្លា Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac	ST. BAL'	TIMORE, MAR	YLAND 21217 Approximate Interval
Medical. Examiner		failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ———————————————————————————————————			Between Onset and Death
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause			
uted nd ransit	Medical Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.			
'60, rate be executed physician and re burial - transit	Medica	UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delive	ry
Division of Vital Records, P.O. Box 68760, To the Haspital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregn 4 Pregnant at time of death 5 Other (Specify) 9 Unknown	ancy	Month	Day Year
P.O. B res that the designed by the be detached:	by Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		obacco use contribute to	
rds, P requires t been sign hould be o	leted		24a. Was	an 24b. Were a	nutopsy findings available completion of cause of
Vital Records, ysician: The law requirents ortificate has been if director, page 2 should	Completed		1 ✓ Yes	ormed? death? 2 No 1	res 2 No
Vital hysician:	Be	25. Was case referred to medical examiner? 1 Yes 2 No	ing Home 5	Residence 6 Oth	er:
rn of \ ding Phy h. After the funeral of	on: To	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Mogth Day Year) Mar 16, 2012 28b. Time of Injury 28c. Injury at Work? 2300 hrs 1 Yes 2 ✓ No	28d. Describe Subject sho	how injury occurred of	
Division of Vital Records, P.O. To the Haspital or Attending Physician: The law requires that th within 24 hours after death. To the Funeral Director: After this certificate has been signed by completely filled in by the funeral director, page 2 should be detach	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	or Town.		Rural Route Number, City
Huspita 24 hours Funcral		4 W Homicide 29a. Certifier (Check only) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, an	d due to the cau	se(s) and manner as sta	ated.
To the within To the compl	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated. 29b. Signature and title of certifier 29c. License number	at the time, date	29d. Date signed (M	
		Therdone U. Box & Thung. D.	ME	March 17, 2012	
1		30. Name and address of person who completed of see of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 900 W. Baltimore Street, I	Baltimore, M	D 21223	
S Regis	tate trar				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 3:25A Bertha Dixon April 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Seasons Hospice e NW Hospita Kandallstown Baltimore If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Hours Director 1 M 2 XF MD 28a-f shov 10b. County 10a. State 10c. City, Town or Location aţ 10d. Inside City Limits Director Examiner must be notified Baltimore MD 1X Yes 2 ☐ No ō 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral Longwood items 11. Marital Status . Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No "natural", or ş 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify. Black Specify: 3 Widowed 4 Divorced Completed Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working 2 should be filed within 72. It and Mental Hygiene.
7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) NA Secretari 12th arade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Paraway Phyllis 19a. Informant's Name elationship (Type, Print 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 8900 Mallard Court Columbia William 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State 04/10/2012 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of F cility Vaugna C. Greene Funeral Sorvices Bandallstown MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate nterval Between Immediate Cause (Final Onset and Death End-Stage lardicimpenthy Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate Exami attending physician and for use as the burial-transi Cause (Disease or injury that initiated events Hospital or Attenting Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death Unknown Day ed by the at detached for signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of page 2 s autopsy performed? death? certificate 2 🗌 No Yes 25. Was case referred to medical funeral director Be 26. Place of Death (Check only one) examiner? 4 Nursing Home 5 Residence 6 Tother Specific A Cospice Other: မ 1 Tes 2 1 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at 28b. Time of Certificate: i ector: After t ir by the funera 28d, Describe how injury occurred 1 Natural 2 Accident 5 \square Pending work?
1 Yes ithin 24 hours aftir death.

the Funeral Director: Aftionpletely filled in by the fur 2 🗌 No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🖃 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within To the

State Registrar

DHMH 17 Rev 06-2011

29b. Signature and title of certifier

MSRijapameNID

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NSRW WALLE MP 2835 Sm. M N S

32. Registrar's Signature

ack

29c. License number

703

DOU 57465

Baltimore

29d. Date signed (Month, Day, Year)

21209

4/3/12

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Laura Agnes Donoho March TAM Medical 2012 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death labot Memorial Hospital at Eastor Eastur Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Months Days 213-34-6471 **Director** 1 🗆 M 2 🍱 F Maryland 11/22/1938 73 or 28a-f show notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🛂 No Talbot Tilqhman MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? iral", or items 23a o Examiner must be Funeral U.S.A. 21522 Coopertown Road 21671 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Yes 2 No If Yes, Give Year or Dates. 1 Never Married 2 Married within 72 hours after 1 ☐ Yes 2 🔀 No Specify: "natural", 3 Widowed 4 Divorced Specify: Completed White the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 11 Cashier Retail Be Maryland 17. Father's Name (First, Middle, Last) Should be file, and Mental H 18. Mother's Name (First, Middle, Maiden Surname) onoho, ပ္ other traumatic Clara Frantum Sam Norwood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 st nt of Health a : If item 27 is 21522 Coopertown Road, Tilghman, MD 21671 Joan Wilhelm / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or o 04/03/2012 Hanover, Maryland 4 Donation 5 Other (Specify) Anatomy Gifts Registry 22. Name and Address of Facility 21. Signature of Funeral Service Licen ee Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, accomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ printer Kes disease or condition Medical resulting in death) Examiner eurs Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence oi) Exami -tran and Due to (or as a consequence of) resulting in death) Last the attending physician Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death detached Unknown 9 Unknown been signed by Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician: The law requires 1 X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? page 2 After this certificate has autopsy performed? 7 ch 1 Yes 2 🗌 No Yes 2 No director, 25. Was case referred to medical Be Hospita 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 🗷 No Other: မှ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) nours after death.

neral Director: After this y filled in by the funeral d 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural work? 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide City or Town, State) within 24 hours Medical 1 St-Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 06-2011

State

Registrar

Date filed (Month, Day

4 2012

32. Registras Sigr

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND, ITEM#23a, perME, C926,4/4/2012 WS State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ zabeth March ZIOZ 2012 Medical Facility Name (if not institution give street and number) **Examiner** 4c. County of Death If Under last birthday) Date of Birth 9. Birthplace (State or Foreign **Funeral** Months (Month, Day, Year) 12/11/1920 1 D M 2 T F New Jersey 155-03-2102 91 Director Usual Residence of Dece or 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director must be notified at 1X Yes 2 □ No MD Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 14 South Lane 21222 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. Completed by 1 ☐ Yes 2X No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify 3 X Widowed 4 Divorced Black Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Musician Music Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 John Scott Minnie Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3308 Ridgeway Road, Harrisburg, PA 17109 Patricia Boatright / Daughter Important: If its any injury or oth 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2X Cremation 3 ☐ Removal from State Chesapeake Crematory 4/3/2012 4 Donation 5 Other (Specify) Beltsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services, PO Box 1413Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Injuries Immediate Cause (Final Physician/ disease or condition resulting in death) Medical ATION APPROVED BY MEDICAL EXAMINED Due to (or as a consequence of) Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to jui as a consequence of attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) CERT Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Pregnant at time of death 5 Other (specify) the 9 Unknown ☐ Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an Director: After this certificate has autonsv perform 2 \square No Yes Yes 25. Was case referred to medical examiner?

1 Yes 2 No completely filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Spe 27. Manner of Death Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred ☐ Natural ☐ Accident 5 Pending Investigation 28f. Location (Street and Number or Rural Route Number, Number of State) Suicide 6 Could not be Place of Injury - At home, farm, street, factory, building, etc. (Specify) 4 Homicide determined roadna within 24 hours a Medical Certifying Physician To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check best of my knowledge, de Gertifying Nurse Practitioner: To the occurred at the time, date and place, and due to only one title of certifier 29b. Signature ar Bu ted cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 01 BERNICE GLORIA DRAPKIN APRIL Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death KESWICK MULTI-CARE CENTER BALTIMORE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Months Days Hours Min. (Month, Day, Year) Director 104-20-6340 1 - M 2 XF 03/01/1925 or 28a-f show notified at 10c. City. Town or Location Director BALTIMORE MD BALTIMORE 10e. Street and Number 10f Zin Code ö 10g. Citizen of What Country? ed other than "natural", or items 23a o event, the Medical Examiner must be Funeral 2810 GRASTY WOODS LANE 21208 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? 1 ☐ Yes 2 🕅 No Black, White, etc. 1 \square Never Married 2 \square Married ģ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify. 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) OWNER INTERIOR DESIGN Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ BENJAMIN KASS DOTTIE 19a. Informant's Name/Relationship (Type, Print) Department of Health and Important: If item 27 is any injury and i 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ELEANOR SCHEFFLER/DAUGHTER 2810 GRASTY WOODS LANE, BALTIMORE, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 Nurial 2 Cremation 3 Nemoval from State 4 Donation 5 Other (Specify) ARARAT CEMETERY 04/03/2012 FARMINGDALE, NY 21. Signature/of Funeral Service Licer 22. Name and Address of Facility $\mbox{SOL LEVINSON \& BROS., INC.}$ 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cards on each line. Immediate Cause (Final Physician/ ADVANCED DEMENTIA disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Examir Lause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? 1 Yes 2 No Pregnant at time of death ed by the at detached f 9 Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate Yes 2 No Vita funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital 1 ☐ Yes 2 No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ✓ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Division of 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending 1 Natural iniury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide Investigation Funeral Director: A etely filled in by the f 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I 29b. Signature and title of 29c. License number 29d, Date signed (Month, Day, Year)

3. Time of Death

Birthplace (State or Foreign Country)

WHITE

STOLLER

Onset and Death

Unknown

1 ☐ Yes 2 ☐ No

2012

21211

NY

10d. Inside City Limits

1 ☐ Yes 2 X No

11:56 AM

2012

N/A

Registrar DHMH 17 Rev 06-2011

State

Dallect 31. Date filed (Month, Day, Year) APR 0 4 2012 700 West

D0059056

Baltimore MO

yoth St

MO

Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Saluje Mo

32. Registrar's

State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Day 012 April 2, 5:44 A. M Joan Patricia Dumler Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Catonsville **Baltimore** Charlestown Care Center g. Birthplace (State or Foreign 7. Age (In yrs. last birthdav) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 6. Sex 1 ☐ M 2 🖾 F **Funeral** Feb. II, Hours Year 1931 Maryland 81 Yrs Director 213-28-3059 Usual Residence of Decedent items 23a or 28a-f show er must be notified at 10d. Inside City Limits 10b County 10c. City, Town or Location 10a. State Director 1 Yes 2 X No Catonsville MD Baltimore 10g. Citizen of What Country? 10e. Street and Numbe Funeral USA 717 Maiden Choice Lane ST407 21228 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc ☐ Yes 2 🖾 No ,0 þ 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: If Yes, Give "natural", Completed 3 😾 Widowed 4 🗌 Divorced Year or Dates event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry College (1-4 or 5+) Elementary/Seconday (0-12) Own Home Homemaker 12 Department of Health and Mental Hygie. Important: If item 27 is marked other i any injury or other traumatic event, th 18. Mother's Name (First, Middle, Maiden Sumame) Be 17. Father's Name (First, Middle, Last) Evelyn S. Hilgeman ည Andrew B. Jones 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1741 E. Lombard Street; Baltimore, MD 21231 19a. Informant's Name/Relationship (Type, Print) Son John G. Dumler 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Glen Burnie, MD 4/4/2012 Atlantic Crematory 4 Donation 5 Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. . Signature of Funeral Service Licensee mo123 1630 Edmondson Avenue; Catonsville MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 20 No
9 Unknown Month Day Pregnant at time of death within 24 hours after death.

To the Funeral Director; After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached to P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📈 Unknown SCVI Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1 Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Be 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes ၉ 28b. Time of 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Death Certificate: Natural 5 Pending work r 1 Yes 2 No Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie R082382 In M. Buttowrut 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 709 Maidenchice La Balto Md 21228 Ann M. Butterworth, CRNP 31. Date filed (Month, Day, Year) 22. Registrar's Signature APR 0 4 2012 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of Ma		artment of Healt		tal Hygier	ne	
			State Registrar		Reg.	No. 2012	10355			
	Physicia Medic		1. Decedent's Name (First, Middle, Shirley A	Files			1	Date of Death Month	Day Year 2 70 12	3. Time of Death 2:59 A M
	Examir	ier	4a. Facility Name (if not institution, 5118 McFaul R	· /		4b. City, Town, or Locat	ion of Death		4c. County of Deatl Baltimo	
	Funeral				e (In yrs. last birthday)			Date of Birth	9. Birt	hplace (State or Foreign
	Director		504 28-8934 Usual Residence of Decedent	1 □ M 2 🛣 F	80 Yrs.	Months Days Hou		Month, Day, Year pt. 22,1	r) Coi	th Dakota
	yland f sho	ig	10a. State 10b. County		10c. City, Town or Lo	cation		_		10d. Inside City Limits
	e Mar r 28a- notifii	Director	Marylard Baltin	more	Rosedale					1 🗆 Yes 2 🔯 No
	vith th		5118 McFaul Re	and		10f. Zip Code 21206		10g.	Citizen of What Co	untry?
	tems	Funeral	11. Marital Status	12. Was Decedent F	ever in U.S. 13.	Was Decedent of Hispanic If Yes, specify Cuban, Mex	: Origin? (Specify Y	res or No-	U.S.A.	ican Indian.
036	e filed within 72 hours after death with the Maryland that Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed by I	1 ☐ Never Married 2X Marrie 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? ed 1 Yes 2 If Yes, Give Year or Dates,	NI	If Yes, specify Cuban, Mex 1 □ Yes 2🄀 No Spe		n, etc.)	Black, White	
5-0	2 hour	plet	15. Decedent (Specify only highes		16a. Dece	dent's Usual Occupation kind of work done during r	most of working	16b.	Kind of Business/	ndustry
2121	within 7, giene. er than t, the Me	Com	Elementary/Secondary (0-12)	College (1-4 or 5	+) life. D	o kkeeper	riost of working	Ci	ity of Ba	ltimore
pu	be filed v ental Hyg ked othe ic event,	Be (17. Father's Name (First, Middle, La				other's Name (Firs			<u> </u>
Maryland 21215-0036	d b Mer ark	D D	Conra				Joseph:			Anderson
	and 2 shoul Health and I tem 27 is ma		Robert Louis Fi			ng Address (Street and Nu McFaul Road		_{ite Number, City} ale, Mar		Code) 1206
ore,	ge 1 and it of Heal if item; or other		20a. Method of Disposition		20b. Place of Dispo	sition (Name of	Date		Location - City or	
imo	Page 1 ment of tant: If it iury or o		1 Burial 2 Cremation 4 Donation 5 Other (\$)	3 L. Bemoval from State Ombmen t	Gardens o		4-6-201		timore	Maryland
Baltimore,	Burial 2 Cremation 3 Removal from State Gardens of Faith 4-6-2012 Baltimore A Donation 5 X on Figure 1 all vige Lensee 22. Name and Address of Facility Ruck Towson Funeral 1050 York Road Towson, Maryland									
Г			23a. Part 1. Enter the disease, or c shock, or heart failure. List on	complications that caused ily one cause on each line	the death. Do not enter	er the mode of dying, such	as cardiac or resp	piratory arrest,		Approximate Interval Between
	Physician Medical		Immediate Cause (Final disease or condition resulting in death)	a	tage (of	D				Onset and Death
4	Examiner		rooming in quality							
	n #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a	consequence of):					
	ecuter and II-trans	Exan	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a	consequence of):					
09	ate be executed physician and the burial-transit	dical		d						
387	rtificat ling ph e as th	/Mec	IF FEMALE:		,					
P.O. Box 687	eath ce attend d for us	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deli Month	very Day Year
O. III	t the de by the stached	Phys	9 🗆 Unknown	9 🗌 Unknown						
ls, P.	requires that the death certifica been signed by the attending p should be detached for use as t	Completed by I	Part II. Other significant condition	s contributing to death bu	ut not resulting in the u	nderlying cause given in P	Part I.			the cause of death?
corc	e law req has bee ge 2 sho	nplet						24a. Was an autopsy		opsy findings available ompletion of cause of
Re	i: The la icate ha r, page	Con						performed? 1 Yes 2	death?	2 🗆 No
/ita	siciar certif directo	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:		_ Other:	Death (Check only			
of \	ig Phy ter this neral o		27. Manner of Death 1 ✓ Natural 5 ☐ Pending	28a. Date of injury		28c. Injury at		Describe how inju	6 Other (Specifurly occurred	5/)
ion	tendir leath. or: Af the fu	ifica	1 Natural 5 Pending 2 Accident Investiga 3 Suicide 6 Could no	ation	- Injury	M 1 Yes 2	2 🗆 No	,	_	
Division of Vital Records,	al or At s after c il Direct ed in by	Certificate:	4 Homicide determin		ry - At home, farm, stre . (Specify)	eet, factory, office		ocation (Street a City or Town, Star	and Number or Rura te)	al Route Number,
_	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director-After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2 L. Medical Exa	Physician: To the best of naminer: On the basis of extended Practitioner: To the	amination and/or invest	igation, in my opinion, deat	h occurred at the tir	me, date and place	ce, and due to the ca	ause(s) and manner stated
_	Nothing within to the comp		29h. Signature and title of certifier	Panemo	book of my followingge,	29c. License numbe	er	29d F	ate signed (Month	Day Voor)
	15 8m				ooth (Itom 02=) (T	000 Joo	5746.	5 4	13/12	
	,		30. Name and address of person who Singapa Kiem!	2835	Smith AV		Baltone	ore MJ	2120	9
	Stat Registra	e	31. Date filed (Month, Day, Year) APR 0 4 2012	32. Registrar	r's Signature					

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** HENORICKSON APRIL 2012 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner RALT Home NUNSING CANDALLITTUN Count 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex **Funeral** 219-26-6096 1 M 2 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21229 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 es 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Blac ş 3 ☐ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be romas 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Boelts more, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriat 2 ☐ Oremation 3 Removal from State tomas 4 ☐ Donation 5 ☐ Other (Specify 21 Signature of Funeral Service 22. Name and Address of Facility Home Elan 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as our lac or respiral ory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner P.O. Box 68760,2 use as the burial-tran Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) signed by the aid 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of autopsy performed res 2 No spital or Attending Physician: hours after death.
neral Director: After this certificat y filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes / 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manper of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital o within 24 hours aft To the Funeral DI 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar

31. Date filed (Month, Day, Year) State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5 400 32. Registrar's Signature

OLD CTRO MA, 21133

APRIL 2 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Hester march Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death imore vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under **Funeral** Days Mir 16 Yrs. **Director** 1 DM 2 D Usual Residence of Decedent show 10b. County 10a. State at 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f 1 Ves 2 No + more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be n Funeral 0 21213 items 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or in Black, White, etc. þ 1 Never Married 2 Married 2 1 Yes Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: BOCK Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4 or 5+) the lahas Ith and Mental Hygie 27 is marked other traumatic event, the Be 17. Father's Name (First, Middle, Last) UNK 18. Mother's Name (First, Middle, Maiden Surname) 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a 0406 emont attimore 21206 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Department of Important: If it any injury or c Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Spe re of Funeral Service 22. Name and Address of Facility Signatur 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Approximate Interval Between Onset and Death Physician/ disease or condition resulting in death) Medical to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate Due to (or as a consequence of) Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical 09289 IE EEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Dav Year Pregnant at time of death 1 ☐ Yes ∠ ■ 9 ☐ Unknown 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autonsy After this certificate 2 No Yes 1 Yes To the Hospital or Attending Physician; within 24 hours after death. funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 XNo Hospital Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 Yes 2 No Accident
Suicide Investigation **Director:** 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number 4 Homicide determined within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 30. Name and add ess of person who completed cause of death (Item 23a) (Type, Print) V 100 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 06-2011

State

Registrar

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hydiene

imuei Hinton,		State of Maryland / Department of Registrar State of Maryland / Department of Registrar		ıygıene Reg. I	No. 201	2 1035		
Physici edical Exami	an/	Decedent's Name (First, Middle,Last)		2. Date of Death Month Da April 1, 2012	ay Year	3. Time of Death 0905 hrs		
		4a. Facility Name (if not institution, give street and number) 4b.	City, Town, or Location of Death		4c. County of Death			
Francis			Baltimore If Under 1 Year If Under 24Hrs	s 8 Date of Birth/A	/M/DD/YYYY) 9. Birti	polace (State or		
Funeral Director		098-41-0/4/0 1 M 2 F Yrs.	Months Days Hours Mir		Foreign			
, any		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits		
Maryland 28a-f show d at once.	tor	MD Baltimore		Lan	Citizen of What Coun	1 Yes 2 No		
9 5 <u>8</u>	I Director	1805 Chapel St.	21213		USA			
r death with th or items 23a must be noti	by Funeral	1 Never Married 2 Married Armed Forces? If Yes 1 Yes 2 No	Decedent of Hispanic Origin? (S , specify Cuban, Mexican, Puerto		14. Race - Americ White, etc.			
2 hours afte "natural", Examiner	d by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's	es 2 x No specify: Usual Occupation (Give kind of		Specify: B1a b. Kind of Business/Ir			
11215-0036 And be filed within 72 hours after the Higher wastural?, anriced other than "natural?, event, the Medical Examiner	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	t of working life. DO NOT use ret	ired)	27./-			
-003 d within rgiene.	Comp	none N/A 17. Father's Name (First, Middle, Last)	18.Mother's Nam	e (First, Middle, Maid	N/A den Surname)			
ID 21215-0036 should be filed within 77 and Mental Hygiene. 77 is marked other than	Be	Samuel Allen Hinton, Jr.		Synnovea				
MD 21215-0036 d 2 should be filed within 7 lth and Mental Hygiene. In 27 is marked other than 1 marked oth	ဥ		ddress (Street and Number or Parklawn Ave					
imore, MD 2 Pages I and 2 shour ment of Health and Intent. If item 27 is no or other traumatic		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State crematory or other	on (Name of cemetery,		Oc. Location - City or			
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite		4 Donation 5 Other Specify: Mt. Zion	Cemetery Ap	r.7,2012		Md.		
Baltimore, MD permit. Pages I and 2 sh Department of Health and Important: If item 27 is injury or other traumat		24. Signature of Euneral Service Licensee 22. Nam 11 4 1	vin B. Scrug	gs Funer St. Bal	al Home	1213		
Physician /Medical	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Sudden Unexplained Dea	th In Infancy			Death		
	Ļ	Sequentially list conditions, b.						
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated						
uted nd ransit		events resulting in death) Last Due to (or as a consequence of): d.						
50, te be executed nysician and	edical	☐ AMENDED 23a,27,28a-f,per	me,g928 6-13-	12 sm				
876(tificate ng phys as the b		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal	death 3 Ectopic pregna		23d, Date of delivery Month Di	ay Year		
Box 68760, c death certificate be executed the attending physician and office use as the burial - transi	Physician/N		(Specify)					
Vital Records, P.O. B. hysician: The law requires that the de this certificate has been signed by the I director, page 2 should be detached it	by Pt	Part II. Other significant conditions contributing to death but not resulting in the und	erlying cause given in Part I.		co use contribute to t	_		
ds, lequires				24a. Was an	24b. Were aut	opsy findings available		
ecor he law i ate has b	Completed			autopsy performed 1 ✓ Yes 2		ompletion of cause of		
tal R	BeC	25. Was case referred to medical examiner?	26. Place of Death (Check					
n of Vi ding Physi a. After this funeral dir	ပို	27. Manner of Death 28a, Date of Injury 28b, Time of Injury		ng Home 5 Res 28d, Describe how				
ion cath.	ation	1 Natural 5 Pending (Month, Dey,Year) 1 Accident Investigation Fd 4-1-12 Fd 7:30	am 1 Yes 2 X No	unknown				
Division of Vital Records, tal or Attending Physician: The law requirers after drives. After this certificate has been sited in by the funeral director, page 2 should be	Certification:	3 Suicide 6 X Could not be determined (Specify) Sound at hom		28f. Location (Street or Town, State Unit I	et and Number or Run 604 Cherr Baltimore,	ycrest Rd.		
Division To the Hospital or Attendi within 24 hours after death. To the Funeral Director:	Medical Ce	4 ☐ Homicide 29a. Certifier 1 ☐ CertifyIng Physician: To the best of my knowledge, death occurred one) 2 ✓ Medical Examiner: On the basis of examination and/or investigation	· · · · · · · · · · · · · · · · · · ·	due to the cause(s)	and manner as state	d.		
To with	Mec	and manner stated. 29b. Signature and title of certifier	29c. License number	29	d. Date signed (Mon.	th, Day, Year)		
		2-70-	O.C.M.E.	A	pril 2, 2012			
		Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD	/. Baltimore Street, Baltir	nore, MD 2122	3			
St Regis	tate trar		,	,				
- regis	للثلث	THE TOTAL PROPERTY OF THE PROP						

DHMH 17 Rev 1/2001 OCME 2006 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	For State Registrar	State of M	larylano	-	irtment of H tificate of D			Reg. No. 2	12	10359
1	Physicia		1. Decedent's Name (First, Middle, Le JANNIE V. IME						2. Date of De Month	Day -	Year 12	3. Time of Death
	Medic Examin		4a. Facility Name (if not institution, given				4b. City, Town, or	Location of Death		4c. County		
ممييه)		SINAI HOSPITAL	OF BALT	more		BALTI				I/A	
	Funeral Director	į	218-26-4341	7. Ag	ge (In yrs. Ias 96	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 10–29	y, Year)	Coun	place (State or Foreign try) GINIA
	show dat	'n	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Loc	cation				1	0d. Inside City Limits
	Aaryla 8a-f s tified	Director	MD. N/A			BALTI	MORE					1 X Yes 2 □ No
	a or 2 be no		10e. Street and Number				10f. Zip Code			10g. Citizen of	What Cour	ntry?
	th with missing the mast	Funeral	4806 ALHAMBRA A	VE .	Ever in II S	13 \	21212 Vas Decedent of Hi	spanic Origin? (Sp	ecify Yes or No-	USA 14 Bac	e - Americ	an Indian.
36	ge 1 and 2 should be filed within 72 hours after death with the Maryland tt of Heath and Mental Hyglene. • If item 27 is marked other than "natural", or items 23a or 28a-f sho • If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ∑ If Yes, Give	>	l:	f Yes, specify Cubar ☐ Yes 2 🏋 No	n, Mexican, Puerto	Rican, etc.)	Blad	ck, White,	etc.
0	hours natura ical E	lete	15. Decedent's			16a. Deced	lent's Usual Occupa	ation	vina	16b. Kind of B	susiness/In	dustry
215	iin 72 le. han "r e Med	Completed	(Specify only highest s Elementary/Secondary (0-12)	College (1-4 or	5+)	(Give I life. D	kind of work done d O NOT use retired)	unng most of work	arig	FACTO)RV	
121	ed within Hygiene. other thai	an h	-8 - 17. Father's Name (First, Middle, Lasi	_0_		PACI	KER	18. Mother's Nam	ne (First, Middle			
and	be filed ental Hy rked oth ic event	To E	JAMES H. HARRI						VALENS			
ary	should be file and Mental I 7 is marked o raumatic eve		19a. Informant's Name/Relationship			100	ng Address (Street a	and Number or Rur	al Route Numbe			
Σ,	and 2 s Health a tem 27 i		ANNA FORBES (DA	UGHTER)			6 ALHAMBR	A AVE. B.		E, MARYI	_	
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	☐ Removal from Stat	e ce	emetery, cren	sition (Name of natory or other place) ORIAL PAR		Date -2012		•	MARYLAND
Balt	permit. Departr Import any inji		21. Signature of Faneral Service Lice	nseeDORETHA	несто		2. Name and Address 721–27 N.					, P.A. LAND 21217
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, su shock, or heart failure. List only one cause on each line.									or respiratory a	rrest,		Approximate Interval Between
Jin.	Physician/		Immediate Cause (Final disease or condition	a. SEP	IS							Onset and Death
silve.	Medical Examiner		resulting in death)	Due to (or a			TOTEL D	IEN COLT	•			
		ner	Se ventially list conditions if any, leading to immediate	b. Due to (or a	Statement of the Principle of the Parket of		LATED PA	ACOULCIN'T				
	outed nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	C								
	cate be executed physician and the burial-transit	alE	resulting in death) Last	Due to (or a	s a consequ	ence on:						
68760	cate b physi s the b	edical		d								
Box 68	e death certifica the attending p hed for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcom 1 Live Birth 4 Pregnant 9 Unknown	n 2 ☐ Fetal at time of d	Ideath 3	Ctopic pregnand Other (specify)	ру ————		- 1	ate of deliv	very Day Year
, P.O.	law requires that the dea has been signed by the a e 2 should be detached f	by	Part II. Other significant conditions	contributing to death	but not resu	ulting in the	underlying cause gi	ven in Part I.				he cause of death?
of Vital Records,	requir been s	Completed					· ·		24a. Was		. Were auto	ppsy findings available
Seco		dwo							per	opsy formed? 2.2.No	death?	ompletion of cause of 2 No
al F		Be C	25. Was case referred to medical examiner?					ace of Death (Che				
Vit	Physic this ce ral dire	은	1 ☐ Yes 2 No 27. Manner of Death	-		ER/Outpatie	ont 3 DOA Oth	4 L Nursing F		how injury occur		y)
n of	ding Phy h. After thi funeral	cate	1 Natural 5 Pending 2 Accident Investiga	28a. Date of ir (Month, L	Day, Year)	injury	worl		26d. Describe	now injury occur	ii eu	
Division	Hospital or Attending Physician: 24 hours after death. Funeral Director. After this certific etely filled in by the funeral director.	Certificate:	3 Suicide 6 Could no	t be 28e. Place of I	njury - At ho etc. (Specify,	me, farm, st	reet, factory, office			(Street and Num. own, State)	ber or Rura	al Route Number,
	Hospital or 24 hours afte Funeral Din stely filled in	Medical	(Chock 2 Medical Ev	hysician: To the best iminer: On the basis o	f examination	and/or inves	stigation, in my opini	on, death occurred	at the time, date	and place, and d	ue to the c	ause(s) and manner stated.
	To the Hosp within 24 ho To the Fune completely f	Ĭ	only one) 3 Certifying N 29b. Signature and title of certifier	urse Practitioner: To	the best of n	ny knowledge	e, death occurred at 29c. Licens	the time, date and p	piace, and due to	the cause(s) and 29d. Date sign	manner as	stated.
•	- SFO		112000	(0)	7) MI	RES	- 000		03125	112	
	·		30. Name and address of person wi	o completed cause o		23a) (Type,	Print)					
	7		DANTELLE CHERS 31, Date filed (Month, Day, Year)	ZICK MD	240 strat's Signal	01 H.	BELVEDER	E AVE. P	ALTIMO	RE, MD a	21215	
	Sta Registi		APR 0 4 2012	Seren 32. Regis	8. 4	arked						

JANTE IMES

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND TTEM#30perDVR, G926, 47472012, WS State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April Dee Lucille Jungers 20**T**2 11:55 Рм Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore 3709 Stansbury Mill Rd. Phoenix Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Hours Min 216-16-2030 **Director** 1 🗆 M 2 💢 F 87 May 19, 1924 Maryland Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 28a-f Baltimore Phoenix Maryland 1 🗌 Yes 2 💢 No 10e. Street and Number 0 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21131 3709 Stansbury Mill Rd. United States "natural", or items death 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Year or Dates. WW II Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 filed within 72 hours after 1 ☐ Yes 2 X No Specify. Specify: 3 X Widowed 4 Divorced Completed white the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) id Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) homemaker 12 own home other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Dick Bertha Dick Page 1 and 2 should be and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 3709 Stansbury Mill Rd. Phoenix, MD 21131 David Jungers/son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dualney Valley Mem GardApr. 4,2012 Timonium, Maryland 21. Signature of Funeral Service Licensee John O. Mitchell TV, Funeral Services of Dulaney Valley, 200 E. Padonia Rd. Timonium, MD 21093 P.A. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician. disease or condition resulting in death) HTN Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Under ying Cause (Disease or injury Examine sician and burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last signed by the attending physician d be detached for use as the buria Physician/Medical UTI death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Day Pregnant at time of death 1 Yes 2 9 Unknown Hospital or Attending Physician: The law requires that the 24 hours after death.
Funeral Director: After this certificate has been signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 nknown ate has been signage 2 should b 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform Yes 2 V director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital ပ္ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phy within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral or 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 1 Natural 28d. Describe how injury occurred 5 Pending injury Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) H0068615 DO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cao Tu 3346 Paper Mill Road Phoenix, Md. 21131 31. Date filed (Month, Day, Year) 32. Registrar's Signature APR 0 4 2012 Registrar

			Please	Type or Pri					•	9	le.	
			For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of rtificate of		and Ment	, ,	001	2 1 (1261
			Decedent's Name (First, Middle, La	st)		ranoato or	Dodan	2. D	Reg ate of Death	No.	3. Time	of Death
	Physicia Medic		Barbara Ann J	ohnson					Month IPRCIT	Day Ye 20	ar 🐧	09 AM
1	Examir		4a. Facility Name (if not institution, giv	street and number)		4b. City, Town	, or Location o			4c. County of E		
	-5		SINAI HOSPITA				IMOR		۲	N/A		
	Funeral Director		5. Social Security Number 6. 5 214-56-4375	5ex 7. Age	e (In yrs. last birthday)	If Under 1 Year Months Day			ate of Birth Month, Day, Ye	ar) 9.	Birthplace (State Country)	e or Foreign
			Usual Residence of Decedent	L M 2 LAF	61 Yrs.			04	1/13/1	950 M	arylan	ıd
	/land f sho	후	10a. State 10b. County		10c. City, Town or L	ocation					10d. Inside	City Limits
	Many 28a- lotifie	Director	MD N/	A		Balti	more				1 🗓 🗎	res 2 No
	th the 3a or t be r		10e. Street and Number	_ 7		10f. Zip Code			10g	. Citizen of What		
	ath wi	Funeral	2910 Reisterst		ia II 6		1215	i=0 (0===if+)/	N-		.A.	
90	e filed within 72 hours after death with the Maryland ttal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	11. Marital Status 1 Never Married 2 Married	12. Was Decedent E Armed Forces? 1 Yes 2 X		Was Decedent of If Yes, specify Cu	ban, Mexican,	Puerto Rican,	es or No- , etc.)	Black, W	American Indian, /hite, etc.	
21215-0036	ours a ttural	Completed	3 Widowed 4 Divorced	Year or Dates.		1 ∐ Yes 2 ☐ X				Specify: E	lack	
5	72 h In "na Medio	nple	15. Decedent's I (Specify only highest g	ade completed)	(Give	dent's Usual Occ kind of work don OO NOT use retire	e during most	of working	DE	e Kadafy ^{usipe}	alley	
212	within giene. er tha the l		Elementary/Secondary (0-12) 12th Grade	College (1-4 or 5	+)	Nursing	-/	stant	Nu	rsing	Home	
nd	al Hyg d oth	Be c	17. Father's Name (First, Middle, Last)						t, Middle, Maid			
Maryland	should be fil and Mental is marked (aumatic ev	욘	Edward Jones				Gera.	ldine	Johns	on		
Mar	2 should be th and Men 27 is marke traumatic		19a. Informant's Name/Relationship (ng Address (Stree						1206
e)	1 and 2 of Health item 27 other tr		Charles Johnso 20a. Method of Disposition	n Vann	20b. Place of Disp	2 Denvi	ew way					1206
altimore,	permit. Page 1 and 3 Department of Healt Important: If item 2 any injury or other once.		1 🗆 Burial 2 🔀 Cremation 3 🗆		cemetery, cre	matory or other p	· ·	Date		Location - City		
불	nit. Partme oortar injur		4 Donation 5 Other (Special Signature of Funeral Service Licen	**	On-site							
m	Depar Depar Impor any in		Dietic	AN.We	lliam 2	joseph ^{dd} 140 N.	Fulto	n Ave.	., Bal	timore	MD21	217
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that caused ne cause on each line.	the death. Do not en	er the mode of dy	ying, such as c	ardiac or respi	iratory arrest,		Approxim Interval B	
~	Physician/		Immediate Cause (Final disease or condition		10US CEL	L CARC	NOMI	TOFF	RIGHT	WHO	Onset an	d Death
7	Medical Examiner		resulting in death)	Due to (or as a	consequence of):							
		er	Sequentially list conditions,		STITIAL consequence of:	LUNG !	>156A	> E			570	engrs
Т	ed nsit	zaminer	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence or):							
	executed n and iat-transit		that initiated events resulting in death) Last	c. Due to (or as a	consequence of):						+	
Š	e be e ysicia ie bur	lical		d								
09/89	certificate be nding physici use as the bu	Mec	IF FEMALE:									
Š	th cer ttendi	ian/	23b. Was decedent pregnant in the past 12 months?		2 🗌 Fetal death 3 [ncy			23d. Date of		
Box	e death the atter	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4 ∐ Pregnant at 9 ☐ Unknown	time of death 5 l	Other (specify)				Month	Day	Year
л Э	hat the ed by detac	P.	Part II. Other significant conditions of	ontributing to death bu	at not resulting in the	underlying cause	given in Part I.	2	3e. Did tobac	co use contribute	e to the cause of	f death?
DO XO Y STRUCTIVE PULMONARY DISCASE State Columbia Columbia									Probably 4	Unknown		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Ves 2 Mo 9 Unknown 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 1 Ves 2 Mo 9 Unknown 9								24a. Was an	24b. Were	autopsy finding	s available	
auti per la								autopsy	? prior death	to completion of	f cause of	
<u>=</u>	ian: T	Be C	25. Was case referred to medical examiner?			26.	Place of Death		Yes 2 vone)	No 1	Yes 2 No	
7	hysic his ce Il dire	욘	1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatie	nt 2 ER/Outpatie	nt 3 🗆 DOA Of	ther: 4 🗌 Nurs	sing Home 5	Residence	6 ☐ Other (Sp	pecify)	
0	ing P	ate:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of injury (Month, Day,			ury at ork?	28d. D	escribe how in	jury occurred		
20	ttend death stor: / / the I	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	e l	A		Yes 2 N					
Ĕ.	l or A after Direc d in by		4 ☐ Homicide determined	building, etc.	y - At home, farm, sti (Specify)	eet, factory, office	2		ocation (Street ity or Town, St	and Number or ate)	Rural Route Nur	nber,
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	29a. Certifier 1 Certifying Phy	sician: To the best of n	ny knowledge, death	occurred at the tir	me, date and p	lace, and due	to the causes	s) and manner as	s stated.	
	the Ho	Med	(Check 2 ☐ Medical Exam	ner: On the basis of exa se Practitioner: To the	amination and/or inves	tigation, in my opin	nion, death occ	urred at the tim	ne, date and pl	ace and due to the	he cause(s) and r	nanner stated.
	North Corr.		29b. Signature and title of certifier			29c. Licen	se number		29d.	Date signed (Mo	onth, Day, Year)	
			James	413135		RES	-00	0	Mi	ARCH, 2	3,2012	-
			30. Name and address of person who	ompleted cause of dea	ath (Item 23a) (Type, i	Print)						

DHMH 17 Rev 06-2011

State Registrar

SINAL HOSPITAL OF BALTIMORE

GAURAY CHAUDIHARY, MBBS
31. Date filed (Month, Day, Year)

APR 0 4 2012

APR 0 4 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend items 18,20b per fh 9929 7-31-12 vt
State of Maryland / Department of Health and Mental Hygiene 20 | 2 | 0362 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 04.10 AM Rose B. Jackson 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/ABaltimore Levindale Nursing Home 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 6. Sex Age (In yrs. last birthday) **Funeral** Carolina Days Months Hours Min. 0/5/11-0V/1929 1 □ M 2 □ Yrs 82 220-20-6494 **Director** Usual Residence of Decedent fshow 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Director 1 X Yes 2 ☐ No Baltimore N/A MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral U.S.A. 21215 2632 Quantico Ave. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 14. Race - American Indian. 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify:Black 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Nursing Home Nursing 12th Grade Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Taska Harry unk Hollie Harry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Page 1 and 2 sl ment of Health a tant: If item 27 is 2632 Quantico Ave:, Baltimore, MD 21215 Dana Cox(Daughter) 20b. Place of Disposition (Name of **Drugid**ter**Ridge**y or other place) **Cedar Hill** Cem. 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Page 1 a Department of h Important: If ite any injury or ot 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Baltimore, MD 04/04/12 4 ☐ Donation 5 ☐ Other (Specify) 23 Name and Address of FB Yown Jr. Funeral Home PA 21. Signature of Funeral Service Licensee unno 2140 N. Fulton Ave., Baltimore, .MD21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CHRONIC RESPIRATORY FAILUR G 1 month Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** RENAL Sequentially list conditions, Due to (or as a consequence of) Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Pregnant at time of death 1 Yes 2 No 9 Unknown Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Division of Vital Hospital or Attending Physician: Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 27. Manner of Death Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Certifying Priyation: 10 the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 68394 MARCH, 28 2012 MD

State

10115

000

ROSE

2434 W BELVEBERE AVE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LEVINDALE

2. Registrar's Signature

ALPNA D ASNANI

4 2012

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registra 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 1:55 Medical 4a. Facility Name (if not institution, give street and nu **Examiner** 4b. City, Town, or Location of Death 4c. County of Death lerce 8. Date of Birth (Month, Day, Ye Dec. 30, If Under 1 Year Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 - M 2 X F Months **Director** 166-22-1478 Pennsylvania Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at **Funeral Director** MD Baltimore Catonsville 1 Tes 2 No 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a marked other than "natural", or items 23a marked other than "natural", or items 23a may injury or other traumatic event, the Medical Examiner must be once. 713 Maiden Choice Lane #2315 21228 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Administrative Assistant Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Matthew McCool Eleanor McNally 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Tully 909 G Street SE; Washington D.C. 20003 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State New Cathedral Cemetery 4/4/2012 Baltimore, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signatur f Fundral Service Linesee 1630 Edmondson Avenue; Catonsville Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwee Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner the attending physician and hed for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Certificate: To Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 5 Other (specify) Day Year 1 | Yes 2 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes Inpatient 2 - ER/Outpatient 3 - DOA 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No Date of injury 28b. Time of 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After (Month, Day, Year) Natural 5 Pending Accident Investigation Could not be Suicide 3 ☐ Sulcide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a, Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bal 31. Date filed Month, Day, Year) 321 Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hydiene 2 0 1 2

		1	For State Registrar	State	of Marylan		artmen <i>tificate</i>			and M		giene 2 Reg. No.	0 2	10364
	Physician	/	I. Decedent's Name (First, Middle, La		Wayne Kla	ase, Sr.					2. Date of Dea	ath P 3 0	20 12	3. Time of Death 7:10 A _M
	Medica Examine		a. Facility Name (if not institution, given Joseph Ritchie House		mber)		4b. City,	Town, or	Location o			4c. Cour	ity of Death	
	Funeral Director			Sex X 1 □ M 2 □ F	7. Age (In yrs. I	ast birthday) 6 Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birl (Mo OA)		9. Birthr Coun	olace (State or Foreign Waryland
	Maryland :8a-f show stified at	Funeral Director	0a. State 10b. County	e George's	10c. Cit	ty, Town or Lo	cation		Bow	vie			1	0d. Inside City Limits
	vith the I 23a or 2 ist be no	eral Di	0e. Street and Number 2702 Balsam Place				10f. Zip	Code	207	15		10g. Citizen o	of What Cour USA	·
936	0 1.5	≥	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	Armed Fo	2 🔼 No ve	1	Was Deced f Yes, spec 1 Yes				cify Yes or No- Rican, etc.)	14. R B Spec	ace - Americ lack, White,	
M 21215-0036	ithin 72 hoursene.	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed		16a. Deced (Give life. D	kind of wo O NOT use	k done a retired)	ation Juring mos n Mana		ing		Business/Inde	unications
A	oe filed wantal Hygi	To Be	17. Father's Name (First, Middle, Las	Franklin	Klase	-l			18. Moth	er's Nam	e (First, Middle, A	Maiden Surna		
ON	2 should be the and Me 27 is mark		19a. Informant's Name/Relationship Sheila Klase Benac / S	er or Rura wie, N	ID 20715	er, City or Towr	, State, Zip (Code)						
17: 1	Page 1 and ment of Heal ant: If item 2 ary or other		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spe		Date /2012	20c. Locatio	n - City or To							
	permit. Departrimporta any inju	Ì	21. Signature of Funeral Service Lice Dorota Marshall	Pol of	Wha	eStall	2. Name ar Maryl			-	vices, PO	Box 1413	Baltimo	ore, MD 21203
(13	Physician/		23a. Part 1. Enter the disease, or co shock, or heart failure. List only Immediate Cause (Final disease or condition	mplications that one cause on	caused the dea	th. Do not ent	er the mod	e of dyin	g, such as	cardiac d	or respiratory and		Approximate Interval Between Opser and Death	
3/30	Medical Examiner uvsician and the burial-transit	dical Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	INE	3			4 months						
77	DIVISION OF VICE INCLUDES, F.O. BOX 001000 within 24 hours after death certificate be execut within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-tra	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live Birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □ 9 □ Unknown										Date of deliv Month	very Day Year
ASE	requires that the	ed by Ph	Part II. Other significant conditions	s contributing to	death but not re	sulting in the	underlying	cause giv	ven in Part	1.	l _	tobacco use co	_	he cause of death?
VIN KL	The law requate has bee page 2 sho	Complet							_		24a. Was auto perf 1 \square Yes	opsy formed?	b. Were auto prior to co death? 1 \square Yes	opsy findings available ompletion of cause of
3	hysician: his certific	To Be	25. Was case referred to medical examiner? 1 Yes 2 No		Inpatient 2			OA Oth	er: 4 🗆 N		k only one) ome 5 🗆 Res			Inpt Hogine
	Attending Physician: r death. ector: After this certific by the funeral director,	Certificate:	27. Manper of Death 1 Natural 5 Pending 2 Accident Investiga 3 Suicide 6 Could no	tion (Mo	e of injury onth, Day, Year) ce of Injury - At h	28b. Time of injury	М] No	28d. Describe			al Route Number,
~	Hospital or Attendin 24 hours after death. Funeral Director: Aftery filled in by the fu		4 Homicide determin	ed build	ding, etc. (Speci	fy)			e date an	d place	City or To	wn, State)		
	the Hos ithin 24 hc the Fund ompletely	Medical	(Check Medical Example of Certifier) 29b. Signature and title of certifier	miner: On the h	seie of evaminati	on and/or inve	stigation, in	my opini arred at	on death o	occurred a	at the time, date	and place, and	due to the cand manner as	ause(s) and manner stated. stated.
	Fo So		> Specillius	gleto	(h) III /	W) 222) (Time	Drin*\	D33	400)		93/3	120	Z
	,2 B.		30. Name and address of person when I have a support the support of the support o	harty III	use of death (Ite	301 N	Cha	le S	Treet	, fa	attime	is M	D 21	212
	Stal Registra		APR 0 4 2		read .	1 So	Med							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ MARCIT 30 2012 12:20 AM STHER Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner BALTIMORE REISTERSTOWN CHERRYWOOD FUTURE CARE 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs 8. Date of Birth **Funeral** Country) Hours Min. 01/13/1922 NY Director 1 M 2XXF 132-10-6829 90 ral", or items 23a or 28a-f show Examiner must be notified at 10b County 10c. City. Town or Location 10d, Inside City Limits 10a State Director MD BALTIMORE REISTERSTOWN 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21136 USA 12513 IVY MILL ROAD 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Bace - American Indian Black, White, etc. 1 Never Married 2 Married Yes 2 X No Completed by Baltimore, Maryland 21215-0036 WHITE 1 Yes 2 X No Specify: Yes, Give 3 XWidowed 4 ☐ Divorced "natural" Year or Dates event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) marked other than Elementary/Secondary (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည SOPHIE UNKNOWN BENJAMIN SHUSTER other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 shou Department of Health and Important: If item 27 is m any injury or other traum 12513 IVY MILL ROAD, REISTERSTOWN, MD 21136 JUDITH KUSHNER/DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State SWINICHER WOLINER 04/01/2012 BALTIMORE, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Causet Approximate Interval Between Onset and Death 8755/75E Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to for as a consequence of: use as the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of 24a. Was an death? 1 🗌 Yes 2 🗆 No To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director. Yes 2 No 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number R088852 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2835 8mist AUSNUE BOSTHONE, HAMY INNI 21209

State Registrar KATHUSSN C. DIAMOND

31. Date filed (Month, Day, Year)

APR 0 4 2012

DHMH 17 Rev 06-2011

APRIL 1, 2012 11:30 a.m.

ROSALIE KLEIN

			Plea	ise Type or I			artment of F			_		jibie.	
		-	For State	State of	iviai yiai i		tificate of L		and w			0.1	
			Registrar 1. Decedent's Name (First, Middle	, Last)			timouto or z	Journ	Т	2. Date of Deat	eg. No.	UT	3. Time of Death
	/sicia /ledic	al .	ROSALIE A			LEIN	I			APRIL		012	11:30 A M
Ex	amin	er	4a. Facility Name (if not institution) STELLA MARIS	_	er)		4b. City, Town, or TIMON		of Death		4c. County	y of Death LTIMC	RE
Fun	eral		5. Social Security Number		. Age (In yrs. k	ast birthday)	If Under 1 Year	If Under		8. Date of Birth		9. Birth	olace (State or Foreign
Dire	ctor		218-18-3454	1 □ M 2 🛛 F	90	Yrs.	Months Days	Hours	Min.	(Month, Day, 01/08/]		Cour	MD
pu how	at	ř	Usual Residence of Decedent 10a. State 10b. County			y, Town or Lo	cation		<u> </u>	,,		1	Od. Inside City Limits
farylar 3a-f s	tified	ecto	MD BAL	TIMORE		OWINGS	MILLS						1 🗆 Yes 2 😾 No
the N	oe not		10e. Street and Number	, I I I I I I I I I I I I I I I I I I I	1	o W III O D	10f. Zip Code				I0g. Citizen of	What Cour	ntry?
15-0036 72 hours after death with the Maryland n'matural", or items 23a or 28a-f sho	nust l	Funeral Director	4730 ATRIUM C	OURT, #350)			117			USA		
death	iner n		11. Marital Status1 ☐ Never Married 2 ☐ Mari	12. Was Deced	es?	S. 13. \	Vas Decedent of H f Yes, specify Cuba	ispanic Ori an, Mexicar	gin? (Spec n, Puerto R	ify Yes or No- lican, etc.)		ce - Americ ck, White,	
21215-0036 within 72 hours after giene. In matural", o	Exam	d by	3 ★ Widowed 4 Divorced	If Van Civa		1	☐ Yes 2 XNo	Specify:			Specify	/: W	HITE
5-0 hour	dical	Completed		nt's Education est grade completed)			lent's Usual Occup		t of workin	g	16b. Kind of B	Business/In	dustry
2121; within 72 giene.	e Me	mo	Elementary/Secondary (0-12)	College (1-4	1 or 5+)	Ìife. D	O NOT use retired)		t or working	9		200	-
d 2 ed wit Hygier	aut, th	as h	12 17. Father's Name (First, Middle, L	astl		BL	SINESS O		ar's Namo	(First, Middle, N		ESTA	ATE
land be filed ental Hy	ic eve	힏	SAMUEL		TERKOW	TTZ		EST		(i mai, iviidale, ii	PINS		
Maryland 12 should be filed 14th and Mental Hy 27 is marked out	other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relations	nip (Type, Print)			ng Address (Street			Route Number,	City or Town,	State, Zip (Code)
and 2 s Health	ier tra		MICHAEL KLEIN	/SON		1509	MAYWOOD	AVEN	UE, I	BALTIMOI	RE, MD	2120)4
			20a. Method of Disposition 1 ↑ Burial 2 □ Cremation	3 Removal from S		lace of Dispo emetery, crer	sition (Name of natory or other plac			ate	20c. Location	- City or To	own, State
Baltimore, permit. Page 1 and Department of Hes Important: If item	njury	1	4 Donation 5 Other (S		BET		EMORIAL			3/2012			COWN, MD
Department	any ir once.		21. Signature of Funeral Survice	acensee			Name and Address Name Address Name 200 REIS			LEVINS			
			23a. Part 1. Enter the disease, or shock, or heart failure. List of	complications that ca	used the deat								Approximate Interval Between
Physic		60 9	Immediate Cause (Final disease or condition			HEART	FAILURE						Onset and Death
Med Exam	dical niner		resulting in death)	Due to (o	r as a consequ	ience of):							
A TAIT		Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (o	r as a consequ	ience of):						-	
1 E E	ransit	Examine	Cause (Disease or injury that initiated events	C									
e exec	burial-transit	al Ey	resulting in death) Last	Due to (o	r as a consequ	ience of):							
760 cate by	d for use as the b			d									
Ser iffi	ust a	M/m	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outc			Ectopic pregnanc				23d. Da	ate of deliv	ery
Bor 68760 deat cerificate he at endir g phys	ed for	Completed by Physician/Medic	in the past 12 months? 1 Yes 2 No		ant at time of o		Other (specify)				M	onth	Day Year
P.O. Is that the gned by the	should be detached	Phy	g ☐ Unknown Part II. Other significant condition			ulting in the u	ınderlying cause gi	ven in Part	L.	23e. Did tol	pacco use con	tribute to t	he cause of death?
S, P ires th signe	d be	d by								1 □ Y	es 2 No	3 🗌 Pro	bably 4 🗌 Unknown
ord v requ	shou	olete								24a. Was a			psy findings available
/ital Reco sician: The law i certificate has t	oage 2	mo			-			***************************************		autops perfor		death?	empletion of cause of
tal Fall Sian: Tall Si	ector, p		25. Was case referred to medical examiner?	11				lace of Dea	ith (Check	_			
f Vit Physic this o	al dire	မ	1 ☐ Yes 2 👿 No 27. Manner of Death	Hospital:	npatient 2 🗆	ER/Outpatier		4 ∐ N					HOSPICE
no or	e fune	cate	1 ▼ Natural 5 □ Pendir 2 □ Accident Investi	ng (Month	n, Day, Year)	injury	work	yai ⟨? Yes 2 □		8d. Describe ho	w injury occur	rea	
Division of Vital Records, tal or Attending Physician: The law requires rs after cleath. al Director. After this certificate has been significate than the presence of the control of the	by the	Certificate:	3 Suicide 6 Could 4 Homicide determ	not be 28e. Place of	of Injury - At ho g, etc. <i>(Specif</i> y		eet, factory, office		2	28f. Location (St City or Town		per or Rura	l Route Number,
Div ital or ital or ral Dir	lled in			Dullalli	g, etc. (Opecin)	,					i, Gialej		
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the deat certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the at ending physician and	completely filled in by the funeral director, page	Medical	(Check 2 Medical E	Physician: To the be Examiner: On the basis Nurse Practitioner:	s of examination	and/or inves	tigation, in my opinio	on, death o	ccurred at t	the time, date an	d place, and du	ue to the ca	use(s) and manner stated.
To the within To the	compl	Σ	only one) 3 X/Certifying 29b. Signature and title of certifier		to the best of t	ny knowleage	29c. Licens		ite and plat		e cause(s) and 29d. Date signe		· ·
			· MANO	20CKNI			RI	491	792	- 1	4/21	1201.	2
is	0		30. Name and address of person								77		
1	Stat		JACKIE JONES, 31. Date filed (Month, Day, Year)	CRNP 230	gistrar's Signa	NEY VA	LLEY RD.	TIM	ONIUM	, MD 21	.093		
Re	gistra		APR 0 4 2012	Beneva	gistrar's Signa	parke							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene / Certificate of Death cedent's Name (First, Middle, Last) 2. Date of Death narch Physician/ Medical Facility Name (if not institution, give street and num A Location of Death 4c. County of Death **Examiner** ohns Hox N/A 1 more Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** 225-36-8350 Director 1 🗶 M 2 🗆 F 83 Apr 8, 1928 Virginia Usual Residence of Deceder 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at Director 1 🗌 Yes 2 🗌 No Rockingham Co. **Elkton** Virginia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11449 White Rose Road 22827 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. 11. Marital Status Armed Force Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) State of Virginia Elementary/Secondary (0-12) College (1-4 or 5+) Government Audit Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Menta Important: If item 27 is marked any injury or other traumatic arrected. ပ Stella 5 4 1 Hubert Liskey Estep 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 327 Phillips Avenue, Browns Mills, NJ Lucinda Holsinger (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Eastlawn Mem Gardens 4/7/2012 Harrisonburg, Virginia 21. Signal o Fund Service Library Service Martin D. Lawson MITCHELL WIEDEFELD FUNERAL HOME, INC Maryland 21212 6500 York Road, Baltimore, 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Paucreatic Can Immediate Cause (Final Advanced omplication Physician disease or condition resulting in death) Medical Due to (as a consequence of) **Examiner** Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examiner Due to (or as a consequence or): as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physicis P.O. Box 68760 IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Year Month Day Pregnant at time of death 1 Yes 2 L 9 Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖼 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical completely filled in by the funeral director, 26. Place of Death (Check only one) Be examiner? Hospital: 1 ☐ Yes 2 M No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ 27. Many r of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 Yes 2 No 1 Natural 5 Pending Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 📝 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the within 2 only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print 10 SIDDIQUI 31. Date filed (Month, Day, Year) State APR O 4 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1	State of Mar State Registrar		artment of F tificate of L			giene Reg. No. 2012	10368
		Physicia	n/	Decedent's Name (First, Middle, Last) Richard Lawton				2. Date of Dea	oth 03, Day 2012	3. Time of Death 3:52 P M
		Medic Examin	au -	4a. Facility Name (if not institution, give street and number)		1 1	Location of Death	norra	4c. County of Deatl	h
	.	_		328 Nicholson Road 5. Social Security Number 6. Sex 7. Age (filter)	n yrs. last birthday)	Essex If Under 1 Year	X If Under 24 Hrs.	8. Date of Birt	Baltime	hplace (State or Foreign
		Funeral Director		213-30-0401 1 ₂ M 2 □ F	79 Yrs.	Months Days	Hours Min.	(Month, Day 03/13/	v, Year) Cou	intry) York
	pur	show	or		Oc. City, Town or Lo	cation	<u> </u>	L		10d. Inside City Limits
20	Maryla	28a-f	Director	Maryland Baltimore	Essex					1 ☐ Yes 2 ^X No
2	vith the	23a or st be r		10e. Street and Number 328 Nicholson Road		10f. Zip Code	21221		10g. Citizen of What Co	
3:52 pm	death \	items ner mu	<u>.</u>	11. Marital Status 12. Was Decedent Eve	r in U.S. 13. V	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame	
(L) 86	hours after death with the Maryland	ral", or Exami	Completed by	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates.	1951- 1 1952 1	1 ☐ Yes 2xxxNo	Specify:		Specify:	White
715	72 hour	"natu edical	plet	15. Decedent's Education (Specify only highest grade completed)	(Give I	dent's Usual Occup kind of work done o O NOT use retired)	during most of work	ing	16b. Kind of Business/	Industry
20/2	within 72	giene. er thar the M		Elementary/Secondary (0-12) College (1-4 or 5+)		nistrato			Construct	ion
	e filed	of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	To Be	17. Father's Name (First, Middle, Last) Arthur Harry Lawton			18. Mother's Nam Virgini		Maiden Surname) Miller	
2,2 aryland	hould t	n and Mental F 7 is marked o raumatic eve		19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street			r, City or Town, State, Zip	Code)
7 5	and 2 s	Health tem 27 other tra		Evelyn Lawton (Wife) 20a. Method of Disposition	328 20b. Place of Dispo			altimor	e, Maryland 20c. Location - City or	
200	Page 1	nent of Int: If it Iy or o		1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	cemetery, cren	matory or other plac	ce)		Baltimore,	
APCIL Baltimore.	эегтіt.	Department of Important: If it any injury or o		21. Smature of Euguni Smuto Licensee					al Home, P. Essex, Mary	
			4	23a. Part 1. Enter the disease, or complications that caused the shook, or heart failure. List only one cause on each line.						Approximate Interval Between
		ysteton/	8 4	Immediate Cause (Final disease or condition	1 CANO	CER				Onset and Death
		Medical xaminer		reulting in death)	onsequence of):					
	_	=	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	onsequence of,:					
	xecuted	al-trans	Examiner	that initiated events	consequence of):		<u></u>			
09	te be e	attending physician and I for use as the burial-transit	dical	d						
J 687	entifica	nding pl	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of					23d. Date of de	livery
S C	Physician: The law requires that the death certificate be executed	he atter	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 1 ☐ Live Birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	Fetal death 3 Lime of death 5	Dectopic pregnant Other (specify)	cy 		Month	Day Year
20	hat the	been signed by the s should be detached	by Phy	Part II. Other significant conditions contributing to death but	not resulting in the t	underlying cause gi	ven in Part I.	23e. Did t	obacco use contribute to	the cause of death?
7 s	quires 1	en sign	ted b					1 🗆		robably 4 🗌 Unknown
7	e law re	has be ge 2 sh	Completed			-		24a. Was auto perfo	psy prior to death?	topsy findings available completion of cause of
3:	ian: Th	r this certificate has aral director, page 2	Be Co	25. Was case referred to medical examiner?		26. P	lace of Death (Chec	1 ☐ Yes k only one)	2 X No 1 ☐ Yes	s 2 No
7	Physic	this ce	은		t 2 ER/Outpatie		4 L Nursing H		dence 6 Other (Spec	cify)
25	Attending	ath. r: After he fune	Certificate:	1 Natural 5 ☐ Pending (Month, Day,	Year) injury	wor	k?] Yes 2 □ No			
Ki	. 6	after death. Director: A I in by the fu	Certi	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury building, etc.	r - At home, farm, str (Specify)	reet, factory, office		28f. Location (S City or Tov	Street and Number or Ru vn, State)	ral Route Number,
	Hospital	within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis of exa	mination and/or inves	stigation, in my opini	ion, death occurred a	t the time, date a	and place, and due to the	cause(s) and manner stated.
	To the	within To the comple	2	29b. Signature ang title of certifier		29c. Licens			29d. Date signed Mont.	
	\	134,9,		30. Name and address of person who completed cause of dea	ath (Item 23a) (Type,	Print)	MIN	アハイ	MINITIM	MN 7102
		Sta	te	31. Date filed (Month, Day, Year) 32. Roman	s Signature	UVCT	VAUCT	MJII	141411	110 400)
		Registr	ar	APR 0 4 2012	J. A.	arka				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** 30 Marie C. 2012 Leicht /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FRANKLIN Square Hospital Baltimore Rosedaly If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Months Days Min. 1 □ M 2 🔀 F Yrs. 12/04/1926 Pennsylvania Director 216-20-6249 Usual Residence of Decedent the Maryland 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 1 ☐ Yes 2X No Maryland Baltimore Essex Director 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 403 Torner Road 21221 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2X No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify þ Specify: White 3 ₩ Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ernest Valt Agnes Magnolia ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 Yew Court, Baltimore, Maryland 21221 Deborah Collurafici (Daughter) 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 04/02/2012 Baltimore, Maryland Oak Lawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Bruzdzinski Funeral Home, p.A. 21. Signature of Funeral Service Licensee 1407 Old Eastern Avenue, Essex, Maryland 21221 Approximate Interval Between Onset and Death 23a. Por 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Due to (or as a consequence of): disease or condition resulting in death) /Medical Examiner omplete Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (Chas a consequence of) Examiner sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day 5 Other (specify) ☐Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 2 1No 1 □Yes completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 □Yes 2 □ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

Division of Vital Records, P.O. Box 68760. Hospital or Attending Physician: 24 hours after death. Funeral Director; After this certifica 24 hours a To the 1 within 2 To the 1

Baltimore, Maryland 21215-0036

Mail

State Registrar 29a, Certifier

(Check only one)

29b. Signature and title of certifier

Hohamad R.

31. Date filed (Month; Day, Year) -

Medical

DHMH 17 Rev 1/2001

ORIGINAL

4000 Frank

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

. I in Squeeve Dr.

29d. Date signed (Month, Day, Year)

, Baltimene MD

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#26perPHYS, G926, 4/4/2012, WS

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year Physician/ 4:33 PM 201 John Brett LeBrun, Sr. March 30, Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Hospital Bel Air Harford 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Days Min (Month, Day, Year) 1 M 2 F **Director** 72 214-36-8656 Dec 13, 1939 New Jersey Usual Residence of Deceden or 28a-f show notified at with the Maryland 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No MD Harford Bel Air 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ems 23a or must be r Funeral 21014 22 Eastern Avenue United States items 2 within 72 hours after death "natural", or item edical Examiner n 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify 3 Widowed 4 Divorced Specify: Completed White the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working is marked other than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Matz Childs Surveyer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Page 1 and 2 should be filk ment of Health and Mental 2 traumatic Howard Vernon LeBrun, Sr. Emma May Barbour 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr. 27 Marlene LeBrun /Wife 22 Eastern Avenue Bel Air, MD 21014 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Apr 03 4 ☐ Donation 5 ☐ Other (Specify) 2012 Beltsville, Maryland Chesapeake Crematory Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation and Funeral Alternatives men 8717 Green Pastures Drive Towson-Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) as a consequence f) Examiner Sequentiany list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last b signed by the attending physician and Due to (or as a consequence of): 10 Physician/Medical use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery Box in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Dav Year Pregnant at time of death P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be the Hospital or Attending Physician: The law requires 2 No 3 Probably 4 Unknown 1 Yes Records, Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has completely filled in by the funeral director, page 2 autopsy performed this certificate 1 Yes 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) Be examiner? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျ 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at work? After 1 Natural injun 5 Pending 1 Yes 2 No Accident Investigation after death 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Continued Technology and manner as stated continued to the time, date and place, and one to the cause(s) and manner as stated continued to the time, date and place, and one to the cause(s) and manner as stated To the I within 2 To the I only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Name and address of person who completed cause of death (Item 23a) (Type, Print). 2101 10 Date filed (M) to Day, Year) 32. Registrar's Signar State APR 0 4 Registrar

1935

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ ERETHA Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Glen Burnie Anne Arundel **Baltimore Washington Hospital Center** If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Min 1 🗆 M 2 ื F Director 213-34-2360 75 Jul 5, 1936 Usual Residence of Deceder 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location filed within 72 hours after death with the Maryland Director Examiner must be notified 1 X Yes 2 No MD Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö items 23a Funeral 21122 U.S.A. 8277 Edwin Raynor Boulevard 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 9 py 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black "natural" Completed 3 Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) **Domestic Private Homes** 12 Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Cordelia Brooks George Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8277 Edwin Raynor Boulevard, Pasadena, MD 21122 William Lane 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) Apr 05, 2012 Lansdowne, MD 4 Donation 5 Other (Specify) Mt. Zion Cemetery 22. Name and Address of Facility 21. Signature of Emeral Service Lice Estep Brothers Funeral Service, P. 1300 Eutaw Place Baltimore, Md 21217 23a. Part 1. Epper the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_{sician/} disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immedia cause. Enter Underlying **To the Hospital or Attending Physician:** The law requires that the death certificate be executed Cause (Disease or injury that initiated events sician and burial-trans Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 1 Yes 2-25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA ပ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d, Describe how injury occurred 1 Natural 5 \square Pending 1 Yes 2 No Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a To the Funeral I Medical 29a. Certifier 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

2 🗌 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

			AMEND #27,28A-F	e Type or Pri PER MD G9 State of M	nt in Bl 30 8/8 aryland	l <mark>ack Ir</mark> 7 12 1 7 Depa	ndelible Ink RT artment of F	. Ens ullealth a	i <mark>re All Copie</mark> nd Mental H	es Are	e Legible	•
		1	State Registrar		,		tificate of E			Reg. No	2010	10372
_	ysicia Medic	_	1. Decedent's Name <i>(First, Middle, L</i> Kenneth R. I	ast) ayne					2. Date of D March		1 ^y 20 1 [™] 2″	3. Time of Death 2:48 AM
W 42	amin	er	^{4a.} Facility Name (if not institution, g Gilchrist Hosp				4b. City, Town, or Towson	Location of	Death	B	altimol	re ce
	neral ector		227-34-9630	. Sex 7. Ag	e (In yrs. last 78	birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	4 Hrs. 8. Date of 8 (Month, D	ay, Year)	Co	thplace (State or Foreign untry) Carolina
aryland a-f show	fied at	ector	Usual Residence of Decedent 10a, State Maryland Harfo	ord	10c. City, T	Town or Local			12,71,			10d. Inside City Limits
with the M	st be noti	eral Dire	10e. Street and Number 1402 Ronson Co	ourt			10f. Zip Code 21001			usa USA	itizen of What Co	
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If the 27 is marked other than "natural", or items 23a or 28a-f show	Examiner mu	by F	11. Marital Status 1 ☐ Never Married 2 ☒ Marrie 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 X Yes 2 □ If Yes, Give Year or Dates.	Ever in U.S.	If	Vas Decedent of Hi Yes, specify Cubar	n, Mexican,	n? (Specify Yes or No Puerto Rican, etc.))-	14. Race - Ame Black, Whit Specify: Wh:	e. etc.
21215-0036 within 72 hours after glene.	he Medica	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 12			(Give l	ent's Usual Occupa kind of work done d O NOT use retired) mobile I	uring most o	of working		Kind of Business	•
land 2 be filed willental Hygirked other	tic event, t	BB	17. Father's Name (First, Middle, Las Unknown	t)			I	18. Mother Nanni	's Name (First, Middle e France	e, Maiden S H	Surname) arris	······································
Maryland of 2 should be filed balth and Mental Hy n 27 is marked off	er trauma		19a. Informant's Name/Relationship Emma Layne / N	_(Type, Print) √ife	1		•		or Rural Route Numb			*
Baltimore, sermit. Page 1 an Operartment of He mportant: If item	jury or oth		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	ecify)	cem	etery, crem Fer	sition (Name of natory or other place ris & Ce	o. 4/		Pen	t Ches nsylva	nia
Bal permit Depar	any in once.		21. Signatur of Experience Vice	anti					Funeral St, Aber		me, P. n, MD	A 21001
Physic Med Exam	dical	i	23a. Part 1. Enter the disease, or co shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death)	omplications that caused yone cause on each line a. Due to (or as a	TAS	TAT	r the mode of dying	g, such as ca	ardiac or respiratory a			Approximate Interval Between Onset and Death Mary THS
	1	Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as:	s consecution	nu cty			N . 57		A	
50 te be executed nysician and			that initiated events resulting in death) Last	c. Due to (or as a	a consequen	ce of):		m	SOUTED BY ME	DICAL EXAM	Wer.	
Division of Vital Records, P.O. Box 68760 Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. Funeral Director: After this certificate has been signed by the attending physicis	ched for use as t	\	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Fetal de	eath 3 🗌	Ectopic pregnanc	, CERT	FICHUO FORBOARD BA ME		23d. Date of de Month	livery Day Year
Is, P.O. uires that the n signed by t	should be detached	ed by Ph	Part II. Other significant conditions LEFT HIF	_			nderlying cause giv	en in Part I.				the cause of death?
Division of Vital Records, ral or Attending Physician: The law requires after death. Bull Director: After this certificate has been significate by the control of the cont	page 2	Completed by	CORONAR PORIPHERM						24a. Was auto per 1 □ Yes	opsy formed2	prior to	topsy findings available completion of cause of
f Vital Re Physician: The this certificate	ector,	Be	25. Was case referred to medical examiner?	Hospital:			26. Pla		(Check only one)			
f Vi Physi this c	<u>ē</u>	<u>۵</u>	1 Yes 2 ☐ No 27. Mann of Death		ent 2 ER	/Outpatien		4 LJ Nur	sing Home 5 Res			ity) HOSPICE
n ol ding F th. After	fune	cate	1	(Month, Day	r, Year)	injury	28c. Injury work' M 1 🗆	aι ? Yes 2 X 1	28d. Describe SUBJEC	-	-	
Division al or Attendir s after death.	ed in by the	l Certificate:	3 Suicide 6 Could no 4 Homicide determine	t be 28e Place of Inju	ıry - At home			A	00000	(Street ar own, State	nd Number or Ru	ral Route Number, DNSON CT
	completely filled in	Medical	(Check 2 L Medical Exa	hysician: To the best of miner: On the basis of e urse Practitioner: To the	xamination an	nd/or invest	igation, in my opinio	n, death occ	urred at the time, date	and place	e, and due to the	cause(s) and manner stated.
To the within To the	COM		29b. Signature and title of certifier MANN	4	heli	1 M	29c. License	number 636	50	29d. Da	ate signed (Monti	h, Day, Year)
+1			30. Name and address of person wh	O. Anki	Zinn R	MAG	701 N	12774	Chance	35	report	PALTINERAM
Re	Stat gistra	_	31. Date filed (Month, Day, Year) APR 0 4 201	32. Registra	ar's Signature	for	21					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 3 - 2 4 - 1 2 Day I.AWAI. MOHAMMED 1:55p м Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George Hospital Cheverly PG 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min. 215-04-2221 59 **Director** 1**X** M 2 □ F 6-2-1952 Nigeria Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d, Inside City Limits Director "natural", or items 23a or 28a-f s edical Examiner must be notified Cheverly Md. PG 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6403 Landover 20785 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Black Completed Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 2 should be filed within 72 h h and Mental Hygiene. 7 is marked other than "n Elementary/Secondary (0-12) College (1-4 or 5+) traumatic event, the Nurse Nursing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Bisiriyu Mohammed Sanni Giwa permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Funke Akapo - Wife 6403 Landover Rd, Cheverly, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗶 Burial 2 🗌 Cremation 3 🗌 Removal from State cemetery, crematory or other place Donation 5 Other (Specify) Lincoln Cemet. 3 - 27 - 12Brentwood, 411kennedy St,N.W. ignature of Funeral Service bicenses 22. Name and Address of Facility Universal Mortuary Inc, Washington, D.C. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or Interval Between Onset and Death Immediate Cause (Final Ph_sician anixia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner warming Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Can ans vision an Cause (Disease or injury that initiated events athensclende the burial-tran and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical law requires that the death certificate be P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No ò Month Day Year g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by mallit Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 □ No Hospital or Attending Physician: The certificate 1 Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending s after death. 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical within 24 hor To the Fune completely fi 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) D004366 2 March 25, 2012

Registrar

DHMH 17 Rev 06-2011

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Pa

Ho

2. Registrar's Sign

Boy

Am

31. Date filed (Month, Day,

12-02509 Charles McClain

Ple	ease Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.			
			2	10374
	Certificate of Death	La V	l	1001

		1- For State Registrar		Certifi	icate of	Death		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Reg. No.		
Physician/ 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year March 29, 2012 4a. Facility Name (if not institution, give street and number) University Hospital 2. Date of Death Month Day Year March 29, 2012 4b. City, Town, or Location of Death Baltimore										W. 30	3. Time of Death
nedical Exam	ine		Charles Benj	amin Mc				March 29), 2012	Year	0341 hrs
1			n, give street and number)		41		Location of De	eath	4c. Cour	nty of Death	1
Funeral		5. Social Security Number	6. Sex 7. Age	(In yrs, last b	hirthday)	If Under 1 Yea	r If Under 24	Um 10 Data at 11	int an emphasis		
Director		217-66-2991	T T	-	• •	Months Day		Min		Foreig	thplace (State or gn
	1	Usual Residence of Decedent	1 M 2 F	55	Yrs.			05/	05/1956	Cou	unt M aryland
Any		10a. State 10b. County		10c. City, Tow	vn or Locatio	n					10d. Inside City Limits
. .	_	MD	Harford				Aberdee	an			1 Yes 2 No
aryland 8a-f show at once.	융	10e. Street and Number		- .		10f. Zip Code	7 tociace		10g. Citizen of	What Cour	
n the Maryland 3a or 28a-f sho otified at once	Director	3530 Churchville Roa	id, Apt. B		İ	,	21001				SA
with us 23, 26, 100	-	11. Marital Status	12. Wes Decedent B	ver in U.S.	13. Was	Decedent of His		Specify Yes or N	0- 14 R:		can Indian, Black,
death r iten	Funera	1 Never Married 2 Ma	Armed Forces?	No	If Yes	s, specify Cuban	, Mexican, Pue	rto Rican, etc.)		/hite, etc.	Tan malan, place,
after al", o	by F		orced If Yes, Give Year		1 1	res 2 No	specify:		Specii	fy:	White
hours		15. Decedent's Education (Spec				S Usual Occupat st of working life.			16b. Kind of	Business/Ir	ndustry
215-0036 se filed within 72 hours tral Hygiene. ked other than "naturent, the Medical Exami	Completed	Elementary/Secondary (0-12) 7	College (1-4 or 5-	+)				eliled)			
5-0036 ed within 7. tygiene. other than	E	17. Father's Name (First, Middle,	Loot		truc	k drive			trans		tion
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be C	Tr. 1 20102 3 Name (1 1131, Miladie,	Charles McClain	Sr			18.Mothers Na	me (First, Middle,	Jane Wo	,	
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiers 77 is marked other than "natural", or items 23a or 28a-f ah matic event, the Medical Examiner must be notified at once	ToE	19a. Informant's Name/Relationsh			9b. Mailing A	Address (Street	and Number of	or Rural Route Nu			7in Code)
e, MD 21215-003 1 and 2 should be filed withi Health and Mental Hygiene, item 27 is marked other th		Theresa McClain / W	ife					t. B, Aberde			21p 0000)
Ce, No. 1 and Health		20a. Method of Disposition		20b. Place	of Dispositi	on (Name of cen	netery,	Date	20c. Locatio		Town, State
Pages ent of nt: I	1 Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: Chesapeake Crematory 4/4/2012 Beltsvi									ille MD	
Baltimore, permit. Pages 1 a Department of He Important: If ite	A Donation 5 Other Specify: Chesapeake Crematory 4/4/2012 Beltsvi 21. Signature of Funeral Septice Licensee Dorota Marskall A Donation 5 Other Specify: Chesapeake Crematory 4/4/2012 Beltsvi 22. Name and Address of Facility Dorota Marskall A Donation 5 Other Specify: Chesapeake Crematory 4/4/2012 Beltsvi A Donation 5 Other Specify: Chesapeake Crematory 4/4/2012 Beltsvi A Donation 5 Other Specify: Chesapeake Crematory 4/4/2012 Beltsvi									ine, me	
ELGS O	Dorota Marskall Durho Llaubuch Maryland Cremation Services, PO Box 1413 Baltim									ore, MD 21203	
Physician		23a. Part I. Enter the disease, or of failure. List only one cause of	complications that caused the	ne death. Do r	not enter the	mode of dying,	such as cardia	c or respiratory em	est, shock, or l	neart	Approximate Interval
/Medical Examiner		Immediate Cause (Final disease	a. Contact Gunshot	Wound of	Head						Between Onset and Death
- 200		or condition resulting in death)	Due to (or as a conseq	uence of):			-				
	-	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conseq	neuce of):							
	盲	cause. Enter Underlying Cause (Disease or injury that initiated	c	401100 017.							
ed asit	Examiner	events resulting in death) Last	Due to (or as a conseq	uence of):						7	
760, frate be executed physician and the burial - transit	g	UNPENDED	d. X AMENDED 16a-	h ner	fh c02	6 /-/-1	2 000				
760, icate be e physicia the buria	/Medical	IF FEMALE:				.0 4-4-1	Z SIII				
876 tificate ng phy as the		23b. Was decedent pregnant in the	23c. If yes, outcome			death 3	Ectopic preg	nancy	23d. Date Month	•	ay Year
Box 68 death certifi the attending of for use as	끯	past 12 months?	4 Pregnant at tir	no of dooth	_ =	(Specify)		, iang	I Worter	55	1921
Vital Records, P.O. Box 68 hysician: The law requires that the death certificate has been signed by the attending of director, page 2 should be detached for use as	Physician	1 Yes 2 No 9 Unkn	9 UNKNOWN								
that the detach	Ď	Part il. Other significant condition	ns contributing to death b	out not resultin	ng in the und	erlying cause gi	ven in Part I.				ne cause of death?
Juires quires an sign		-		-							ibly 4 Unknown
ord aw rec as bee	Completed							24a. Was autop		prior to con	opsy findings evailable impletion of cause of
Rec The L	performed? death? 1 ✓ Yes 2 No 1 ✓ Yes 2									2 No	
certifi ector,	8	25. Was case referred to medical examiner?	11-2				of Death (Chec	k only one)			
of Vital Records, P.O. ng Physician: The law requires that the Wher this certificate has been signed by meral director, page 2 should be detach	2	1 ✓ Yes 2 No	Hospital: 1 Inpatient		utpatient 3			ing Home 5	Residence 6	Other:	
ding Ph. After ti		27. Manner of Death 1 Natural 5 Pendir	28a. Date of Injury (Month, Day Year Mar 28, 2012) 28b.	Time of Injur		_	28d. Describe I Subject sho		пед	
SiO Atten r deatl ector:	cati	2 Accident S Pendir	gation				s 2 🗸 No				
Division tal or Attendir rs after death. al Director: A led in by the fu	Certification:	3 ✓ Suicide 6 Could determ				actory, office bu	lding, etc.	or Town, S	tate)		I Route Number, City
Tospit 4 hour nuner		4 Homicide	(Opening) William					3530 Churchv			
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	(Check only one) 2 ✓ Medical Exam	sician: To the best of my k	nowieage, ae: nation and/or i	ath occurred investigation	at the time, date , in my opinion, o	e and place, an death occurred	id due to the caus at the time, date a	e(s) and mann and place, and	er as stated due to the	cause(s)
To To	Š	29b. Signature and title of certifier	and manner stated.			29c. License			29d. Date sig		
1.~		D-2)-				О.С.М	.E.		March 29,		., _ 27, . 001,
/ Ehr	ŀ	30. Name and address of person w	ho completed cause of dear	th (Item 23a)		<u> </u>					
		Donna M. Vincenti, MD	Assistant Medical	Examiner		. Baltimore S	Street, Balti	more, MD 212	223		7
Sta	ate	31. Date filed (Month, Day Year) APR 0 4 2012	32. Registrar	Signature	Last -	-					
Regist	ar	APR 0 4 2012	Marine 10.	1900							

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			for State	ate of Maryland				Mental Hy	giene		
			Registrar		Cer	tificate of D	eath		Reg. No. 2	012	10375
	Physicia Medic		Decedent's Name (First, Middle, Last) R	obert J. Mitch	ell		_	2. Date of De Month April	2, 2012	Year	3. Time of Death 3:05 P M
	Examin	er	4a. Facility Name (if not institution, give street			4b. City, Town, or			4c. Count	y of Death	
	Funeral		523 Savage Street, 2nd Floor 5. Social Security Number 6. Sex	7. Age (In yrs. last	birthday)	If Under 1 Year	Baltimore		th	9 Birthn	place (State or Foreign
	Director		219-30-6270 1 M :		Yrs.	Months Days	Hours Min.			Count	Taryland
	land show d at	ρį	10a. State 10b. County	10c. City, T	own or Loc	ation				1	0d. Inside City Limits
	Mary 28a-f lotifie	Director	MD				Baltimore				1 X Yes 2 □ No
	ith the		10e. Street and Number			10f. Zip Code	21224		10g. Citizen of	What Coun	
	eath w	Funeral		as Decedent Ever in U.S.	13. W	as Decedent of His	spanic Origin? (S	pecify Yes or No-	14. Ra	ce - America	
980	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 Never Married 2 Married 1	med Forces? X Yes 2 \sum No Navy Yes, Give ear or Dates.		Yes, specify Cubar ☐ Yes 2 X No		to Rican, etc.)	Bla Specify	ck, White, e	etc. hite
2-0	hour fratur	plete	15. Decedent's Education (Specify only highest grade cor	n 1	16a. Deced	ent's Usual Occupa ind of work done du	tion	rkina	16b. Kind of E	Business/Inc	Justry
121	within 72 giene. Ier than '	Completed	Elementary/Secondary (0-12) Co	ollege (1-4 or 5+)		NOT use retired)	Worker	9		Steel N	/iii
d 2	ed wit Hygie other ent, th	Be C	10 17. Father's Name (First, Middle, Last)			Steel		me (First, Middle,	Maiden Surnam		1111
ılan	d be filed dental Hy irked oth tic event	2	Robe	rt Mitchell					tha Stzelcz		
lan	should be file and Mental I 7 is marked o raumatic eve		19a. Informant's Name/Relationship (Type, Pri	1.1		g Address (Street a			-		ode)
e, r	and 2 s Health tem 27		Christina Lynn Clark / Comi			Savage Street	t, 2nd Floor				Challe Challe
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other once.		1 ☐ Burial 2 X Cremation 3 ☐ Remo	val from State cem	etery, crem	atory or other place ke Cremator	•	Date /4/2012	20c. Location	eltsville	
äţį	mit. Poartme		21. Signature of Funeral Service Licensee	d O	-	Name and Address		4/2012	В	CIGVIIIC	, WID
ä	permir Depar Impor any ir once.	_	Dorota Marshall Jour	le Gleas	hall	Maryland Ci	remation Se	ervices, PO	Box 1413I	Baltimor	re, MD 21203
			23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cause	ns that caused the death. D se on each line.	o not enter				rest,		Approximate Interval Between Onset and Death
	Phylician Medical		Immediate Cause (Final disease or condition resulting in death)	METASTA	TIC	MET	ANON	1A			> NONTH
	Examiner			Due to (or as a consequent	ce oi):						
		iner	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequent	ce of):						
	scuted and -transi	Examiner	Cause (Disease or injury that initiated events c.	Due to (or as a consequent	ce of:		_				
	cate be executed physician and is the burial-transit	edical E	resulting in death) Last	Das to for as a consequent	00 01).						
3760	ficate g phys as the		d								
Box 68760	To the Hospital or Attanding Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending is completely filled in by the funeral director, page 2 should be detached for use as	Physician/M	in the past 12 months?	yes, outcome of pregnancy Live Birth 2 Fetal de	eath 3 🗌		,			ate of delive	ery Day Year
8 B	ne deal r the af	ysic	1 Ves 2 No 4	Pregnant at time of deat Unknown	th 5∐	Other (specify)			101	51101	Jay Teal
P.O.	that the ned by e deta	by Pr	Part II. Other significant conditions contribut	ing to death but not resulting	ng in the un	nderlying cause give	en in Part I.	23e. Did to	bacco use con	tribute to the	e cause of death?
ds,	quires en sig ould b	ted t						1 🗆 '	Yes 2 □ No	3 🗌 Prob	ably 4 Unknown
Division of Vital Records,	law re has be ge 2 sh	Completed						24a. Was autop	osy		sy findings available npletion of cause of
Be	ding Physician: The la h. After this certificate ha funeral director, page		25. Was case referred to medical			00. DI		1 Tes	2 No	1 Yes	2 🗆 No
/ita	/sicial s certii directo	To Be	examiner? 1 \(\sum \text{Yes} 2 \text{ No} \) Hospita	ıl: 1 ☐ Inpatient 2 ☐ ER.	/Outpatient	Other	ce of Death (Che	Home 5 Resid	lence 6 \(\text{Ott}	er (Specify)	
of	ng Ph) ter thi	te: 1	27. Manne of Death 1 Natural 5 Pending		b. Time of injury	28c. Injury work?	at	28d. Describe h			
ion	tendir Jeath. tor: Af the fu	Certificate:	2 Accident Investigation			M 1 □ Y	∕es 2 □ No				
ivis	I or Attendi after death Director: A d in by the f		4 Homicide determined	e. Place of Injury - At home building, etc. (Specify)	, farm, stree	et, factory, office		28f. Location (S City or Tow		er or Rural i	Route Number,
	To the Hospital or Attenc within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier 1 Certifying Physician:								
	the Ho hin 24 the Fu	Mec		the basis of examination an titioner: To the best of my k		death occurred at the	e time, date and p				
	10 with		29b. Signature and title of contifier	noe MT		29c. License	number		29d. Date signe	d (Month, D	ay, Year)
	24		30. Name and address of person who complete	ed cause of death (Item 23	a) (Type Pr	<u> ソのと</u>	3782		HPYI	4,2	,2012,
	2 21		401 NORTH	BROADU	MY	ROOM	1363	BALT	MORE	MI) 21231
	Stat Registra		31. Date (led (Month, Day, Year) APR 0 4 2012	32. Registrar's Signature							
			A CONTRACT		No.						

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 Decedent's Name (First, Middle, Last) 2. Date of Death 5:35 AM Physician/ Montoch Barbara Louise Masterson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore-Washington Medical Center Anne Arundel Glen Burnie 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min onth, Day, Year) 02/19/1927 1 □ M 2 F Director 314-22-7436 85 Indiana Yrs Usual Residence of Deced with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f 1X Yes 2 □ No MD Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò ms 23a or must be r Funeral 733 Stafford Hill Drive 21061 items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Examiner Armed Force Black, White, etc. ö by 1 Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify. "natural", Completed 3 ☐ Widowed 4 🄀 Divorced White the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Cook - Dietician Healthcare 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ent of Health and Mental Hat; If item 27 is marked otly or other traumatic even ၉ Albert E. Shields Nellie K. Green 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important; If item 27 is any injury or other tra Cheryl Radcliffe / Daughter 733 Stafford Hill Drive, Glen Burnie, MD 21061 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date ☐ Burial 2X Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Chesapeake Crematory 4/2/2012 Beltsville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services, PO Box 1413Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final uve Onset and Death Pa ongestive Physician/ disease or condition Medical resulting in death) **Examiner** all Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events resulting in death) Last burial-tran and Due to (or as a consequence of) attending physiciar Physician/Medical The law requires that the death certificate be P.O. Box 68760 for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) ____ in the past 12 month Month Dav Year Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director, After this certificate I 2 M No 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 Yes 2 No ျှ 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. May er of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural work? 1 ☐ Yes 2 ☐ No M Accident Investigation completely filled in by the Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29b. Signature and title of certifie 29d. Date signed (Month 2012 Maine and address of person who comply 0 MIR 31. Date filed (Month State 4 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 06-2011

Registrar

APR 0

85

0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

intorno man		1- For State Registrar Certificate of Death	i iygi		g. No.	Ul	2 103
Physicia	n/	Decedent's Name (First, Middle,Last)	M	ate of Death	Day Yea	ar	3. Time of Death 1349 hrs
Medical Examir	ıer	Antonio R. Mull 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of De		arch 29,	4c. County (of Death	1549 1115
		Union Memorial Hospital Baltimore					
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24		Date of Birth	(MM/DD/YYYY	9. Birth	
Director		212-25-3331 1 Months Days Hours Months Months Days Hours Months	Min. F	eb.1	4,1988		ntry) MD
any		Usual Residence of Decedent 10a, State 10b, County 10c, City, Town or Location					10d. Inside City Limits
		MD Baltimore					1 Yes 2 No
Maryland 28a-f show	Director	10e. Street and Number 10f. Zip Code		10	g. Citizen of Wh	nat Count	iry?
the M a or 2		3905 Greenmount Avenue Apt 1 21218			USA		
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at once	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Armed Forces? If Yes, specify Cuban, Mexican, Pue			14. Race White		an Indian, Black,
ter dea		1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify:			Specify:	Blac	r.k
ours af	흥	15. Decedent's Education (Specific only highest grade completed). 15g. Decedent's Listial Occupation (Give kind.		ione	16b. Kind of Bu		
6 72 hc	휥	Elementary/Secondary (0-12) College (1-4 or 5+) Office Service C1			Ctata	٥f	Marriand
5-0036 led within 72 hours af Hygiene. typiene. to ther than "natural the Medical Examin	Completed	12th Office Service Ci			aiden Surname		Maryland
21215-0036 Juld be filed within 7 I Mental Hygiene. I marked other than it creent, the Medic	Be C	17. Father's Name (First, Middle, Last) Anthony Mull Yolanda Fran			alderi Surriame,	,	
10re, MD 2121 sges 1 and 2 should be fi nt of Health and Mental t: If tiem 27 is marked other traumatic event,		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of					
ore, MD 2 ges 1 and 2 shou t of Health and 1 : If item 27 is re- ther traumatic		Yolanda Franklin (mother) 4755 Homesdale A					
		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	Dat	- 1	20c. Location -	•	
Baltimore, permit. Pages 1 ar Department of Hec Important: If ite		4 Bendaen S Saler Speeky.			.2 Ba		Md.
Baltimo permit. Page Department o Important: injury or oth	Į	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cal Vin B. Scru 1412 E. Presto	iggs	Fune	eral H	ome	21213
Physician	-	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia	ac or resp	iratory arres	st, shock, or hea	art	Approximate Interval
/Medical	ı	failure. List only one cause on each line. Immediate Cause (Final disease a. Cardiac Arrhythmia				1	Between Onset and Death
- A	- 1	or condition resulting in death) Due to (or as a consequence of): Debyd retion					
	ᡖ	Sequentially list conditions, if any, leading to immediate b. Dehydration Due to (or as a consequence of):				\dashv	
	Examiner	(Disease or injury that initiated events resulting in death). Last levents resulting in death levents resulting resu					
		events resulting in death) Last Due to (or as a consequence or): d.					
× g ÷	Medical	☐ AMENDED 23a-c,27,per me,g927 5-7-12 st	m				
760, icate be ex physician the burial		IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the			23d. Date of	,	
cath certific attending p	ۊ	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnant at time of death 5 Other (Specify)	gnancy		Month	Da	y Year
Box 687 c death certific the attending p ted for use as th	Physician/	1 Yes 2 No 9 Unknown 9 Unknown			<u></u>		
P.O. res that the signed by be detach	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		_		_	e cause of death?
quires en sign			-	24a. Was ar			psy findings available
Law relate be has be	Completed		-	autopsy perform	/ р		mpletion of cause of
tal Rection: The certificate ector, page	ទ្ធ	25. Was case referred to medical 26. Place of Death (Cher	1	✓ Yes 2	No 1	✓ Yes	2 No
sician sician is certi	ŭΙ	examiner? Hospital: Innation 2 FR/Outpatient 3 DOA Other, Nur		- 1	esidence 6	Other:	
ing Phy After th	۹	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?			w injury occurre	∍d	
ion tendir ceath.	[즱	1 X Natural 5 Pending 2 Accident Investigation (Month, Day, Year) 1 Yes 2 No					
ivis lor At after d Direc	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.		ocation (Stror Town, Sta		r or Rura	I Route Number, City
Ospital hours a neeral 1		4 Homicide determined (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a		- 4h	(a) and manner		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurre					
To With	ğΙ	29b. Signature and title of certifier 29c. License number			29d. Date signe	d (Monti	h, Day, Year)
		Carol Hallan O.C.M.E.			March 30, 2	:012	
tes	ľ	30. Name and address of person who completed cause of death (Item 23a)	MD 24	222			
9400	te.	Carol Allan, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, 31. Date filed (Manth, Dax Xear) 32. Registrar's Signature	IVIU ZT	223			
Sta Registr	ie ar						

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day It 3. Time of Death A M Physician/ Month 30 2013 MARCH Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** BALTIMORE RANDALLSTOWN NORTHWEST HOSPITAL 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** Social Security Number Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🗓 F 08/29/1929 Director 220-24-9780 82 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Tes 2 X No BALTIMORE BALTIMORE 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 303 GLATISANT PLACE 21208 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 X No Specify: If Yes, Give Specify: WHITE 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) CLERK OF THE CIRCUIT COURT BALTIMORE COUNTY is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည PAUL COOPER JENNIE COOPER Page 1 and 2 should ment of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SPENCER MENSH / SON 210 ARMS CHAPEL ROAD, REISTERSTOWN, MD 21136 Department of Healtl Important: If item 2: any injury or other tonce. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 💹 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) MARYLAND VETERANS 04/02/2012 OWINGS MILLS, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the decase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) GASTROINTESTINAL Medical Due to (or as a consequence of) **Examiner** MEMI Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death Day 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown DEMENTIA 24b. Were autopsy findings available prior to completion of cause of death? performe Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes ပ 2 X No 1 Nnpatient 2 ER/Outpatient 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28c. Injury at work? Certificate: 28a. Date of injury 28b. Time of 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 1 Yes 2 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined To the Hospital within 24 hours a To the Funeral E Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier rella mo D 41410 28 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) To GIN DER MEHTA RAMORUS TOWN HOSPITAL JYORTHWEST 31. Date filed (Month, Day, Year) State APR 0 4 2012 Registrar

Maryland 21215-0036

Baltimore,

P.O.

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM# 1 per PHYS, G926, 4/23/2012, WS

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last)
Corinne Norton
Corine Norton 2. Date of Death Physician/ Month March 19 Day 2012 2:30 РМ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 570 Bellerive Rd. Apt 342 Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** an 30, 1953 Months Days Hours Callifornia 527-02-7060 Director 59 1 □ M 2 🛣 F Usual Residence of Decedent shov 10a. State 10c. City, Town or Location at 10d. Inside City Limits Director notified 28a-f 1 Yes 2X No MD Anne Arundel Annapolis 10e. Street and Number 23a or 10f. Zip Code 10g. Citizen of What Country? ed other than "natural", or items 23a o Funeral 21112 USA 570 Bellerive Rd; Apt 342 Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White 3 Widowed 4 XDivorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene, is marked other than Elementary/Secondary (0-12) 12 College (1-4 or 5+) psychologist FBT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ပ Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic eronce. Helena Booth Frank R. Norton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1129 Thompson Ave; Severn, MD 211444 John Ryan - exhusband 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 🛛 Other (Specify) in state 21. Sign to of Euneral Service in Ronal d 22. Name and Address of Facility State Anatomy Foard 655 W. Baltimore St; Baltimore, MD 21201 Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition Onset and Death Ph_sician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate Exami use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of attending physician Physician/Medical P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ To the Hospital or Attending Physician: The law requires that the death Pregnant at time of death Month Day been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perforn certificate 1 Yes 2 No Yes 2 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner?
1 \sum Yes 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 03/23/20/2 anu Ramona G Seldel, MD, LLC 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 32. Registrar's Signature

Seidel

amona

269 Peninsula Farm Rd. Ste F

Arnold, MD 21012

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ROBERT M. PIASKOWSKI 03:10 PM MARCH 2012 30 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL MEDSTAR HARBOR BALTIMORE Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last hirthday) 8. Date of Birth Funeral Hours Min 01/26/1947 1 X M 2 □ F Director Maryland 218-44-5958 65 Yrs Usual Residence of Decedent show 10a. State 10b. County 10d. Inside City Limits at 10c. City, Town or Location filed within 72 hours after death with the Maryland Director ems 23a or 28a-f sh r must be notified a 1 X Yes 2 No MD Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 1730 Saunders Way 21260 **USA** 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No Army If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: "natural" Completed White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Truck Driver Transportation event, t Be t. Page 1 and 2 should be filed rument of Health and Mental Hy rant: If item 27 is marked oth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Edward Piaskowski Gertrude Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert J. Maygers / Son 11318 Bridlewood Drive, Unionville, VA 22567 Department of Healt Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 4/3/2012 Chesapeake Crematory Beltsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services, PO Box 1413Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ SEPTIC SHOCK disease or condition resulting in death) HOURS Medical Due to (or as a consequence of): Examiner PERITONITIS HOURS Sequentially list conditions, if any, leading to immediate cause. Enter onderlying Cause (Disease or injury Examine Due to (or as a consequence of) DAYS PANCREATIC CANCER burial-trai that initiated events Due to (or as a consequence of): resulting in death) Last signed by the attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? ģ Month Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 X Yes 2 No 3 Probably 4 Unknown DEMENITIA, HYPERTENSION! been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an MELLITUS TYPE this certificate has autopsy page 2 performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗷 No မ 1 M Inpatient 2 ER/Outpatient 3 DOA filled in by the funeral 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred After injury 1' Natural 5 Pending To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Day, Year) RES OOI MARCH 30 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SOUTH HANOVER STREET, BALTIMORE, MD-21225 VISHAL VASAVADA 3001

DHMH 17 Rev 06-2011

Registrar

31. Date filed (Month, Day, Year)

APR 0 4 2012

acked

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State State Registrar	e of Maryland		irtment of H tificate of L			giene Reg. No. '	2012	10382
	Dhuaici		Decedent's Name (First, Middle, Last)		- ,	, ,		2. Date of De Month	ath Day	Year	3. Time of Death
	Physicia /Medic	_	Michael	POREI	msk			3	26	2012	1210 AM
	Examin	er	4a. Facility Name (If not institution, give street ar			4b. City, Town, or			4c. C	ounty of Death	
- 04	Funeral		Genesis Hamilton H	7. Age (In yrs. la:		Baltime If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	th Variable	9. Birth	place (State or Foreign
ŀ.	Director		219 03 0934 184 2D	[]] F 94	Yrs.	Months Days	Hours Min.	(Month, Da 09 14	1917		MD
	pu »		Usual Residence of Decedent 10a, State 10b, County	10c City	Town or Lo	cation					10d, Inside City Limits
	faryla shov ed at	or			aden						1 □Yes 2 X No
	the N 28a-	Director	MD Anne Arund	er ras	auen	10f. Zip Code			10g. Citize	n of What Cou	ntry?
	h with	al Di	179 Park RD				21122		Ţ	J.S.A.	
	r deat ems 2 er mu	Funeral	11. Marital Status 12. Was	Decedent Ever in U.S ed Forces?	13. \	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (Spo n, Mexican, Puerto	ecify Yes or No Rican, etc.)	- 14	. Race - Ameri Black, White	
36	s afte ,, or it	by Fu	If Ye	Yes 2 X No es, Give r or Dates:		I∐Yes 2⊠No	Specify:		s	pecify: 1.7	hite
8	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show dical Examiner must be notified at	ed t	15. Decedent's Education		16a. Deced	lent's Usual Occupa	ation		16b. Kind	of Business/Ir	
215	hin 72 e. an "na Medik	Completed	(Specify only highest grade complete Elementary/Secondary (0-12) College eted) ege (1-4or 5+)	life. L	kind of work done of OO NOT use retired) -	ing				
7	ed wit ygien yer tha	Соп	7		Shor	Handle		(F)-4 A 62-d-11-			Smelting
and	be fill ad oth even	Be	17. Father's Name (First, Middle, Last)	l. D	1- <i>2</i>		18. Mother's Name			,	
ž	hould nd Mei mark matic	ဥ	J O S 19a. Informant's Name/Relationship (Type. Prin	seph Pore		g Address (Street a					ip Code)
Z	nd 2 saith ar 27 is r trau		Dorothy Donnelly -		179	Park Rd	Pasade	ena, M	D 2	1122	
Jre,	es 1 and 2. of Health a item 27 is r other trau		20a. Method of Disposition	20b. Pla	ace of Dispo	sition (Name of natory or other plac	-	Date	20c. Loca	ation - City or T	own, State
Ē	Pagement ment		1 ■ Burial 2 □ Cremation 3 □ Removal 4 □ Donation 5 □ Other (Specify)	Gle		zen Mem					
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee		100	. Name and Addres	90			neral na, MI	Home, PA) 21122
			23a. Part1. Enter the disease, or complications shock, or heart failure. List only one cause	that caused the death. e on each line.	Do not ent	er the mode of dyin	g, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
5	Physician		Immediate Cause (Final disease or condition resulting in death)	end St	acc	deme	utea				Onset and Dead
1	/Medical Examiner		Di Di	u (or as a conseque	en 🌛 f):	4 Dr	sease				
		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ue to (or as a conseque	ence of):	3 100	,	100 4			
	cuted nd ransit	Examiner	that initiated events	essent	ial	hyp	es ten.	Sin			
30,	icate be executed physician and the burial-transit	EX	resulting in death) Last D	ue to (or as a conseque	ence of): 1270 L	demer 's Dr hyp	+ Dic	ease			
68760,	icate be executed physician and the burial-transit	dical	d. <u>/1)</u>	- rur o 3 21	CIUF	/400.	11 1008				
				es, outcome pf pregnar		7			23	d. Date of deli	very
. Box	death e atter d for u	Physician/M	in the past 12 months?	Live birth 2 Fetal		∐Ectopic pregnancy ☐ Other <i>(specify)</i>				Month	Day Year
P.0.	at the by th	hys	9 □ Unknown	Unknown				1 00 011			
Division or Vital Records, I	law requires that the death certif as been signed by the attending 2 should be detached for use as	by	Part II. Other significant conditions contribution Chromic Lymph	g to death but not resul	Iting in the u	nderlying cause give	en in Part I.			e contribute to No 3 ☐ Pre	the cause of death? obably 42Unknown
900	e law re has bee je 2 sho	Completed	Chronic Lymph	OID LE	cuke	mid		24a. Was		24b. Were au	topsy findings available completion of cause of
ž	The ate h	Com						perf 1□ Yes	ormed? 2 A No	death? 1 ☐ Yes	_
/ita	ysician: Th is certificate director, pag	Be (25. Was case referred to medical examiner? Hospital			Loub	26. Place of Deal				
or	S S	<u>۲</u>	Tes ZENO	T Inpatient 2 □ E	ER/Outpatier 28b. Time o		er: 4 Nursing Ho	ome 5 ☐ Res 28d. Describe			cify)
on	Attending Phr r death. ector: After thi by the funeral	tion	1 Natural 5 Pending 2 Accident Investigation	(Month, Day Year)	Injury	Wor	k? Yes 2 □ No		,,,,,		
Visi	Atter er deal rector by the	Certification:	a□ autite	Place of injury - At hor building, etc. (Specify,	me, farm, str	reet, factory, office			(Street and	Number or Ru	ral Route Number,
Ö	Hospital or 24 hours afte Funeral Dir tely filled in	Cer	V								
		Medical	29a. Certifier 1 Certifying Physician: (Check only one) 2 Medical Examiner: Or and								
	To the within To the comple	Me	29b. Signature and title of certifier	501.15	me d	29c. Licens	,			signed (Monti	h, Day, Year)
			reason ?	- C	(NF	7	05 + 62	25	03	126	12012
	1 V		30. Name and address of person wherecomplete MARCLALL SQUARE 31. Date filed (Month PR' 0'4 2012	Sman C.	23a) (Type,	Print) 32	08762 1 Norx	1 20	UD	2110	/
	Sta	ate	31. Date filed (Month Thy Year)	32. Fegistrar's Signat	ure	7	ve irect	- / /	· v 10	-100	
	Regist	rar	APK U 4 2012	Deven.	1. 4	acker					

Please Type ord Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** QUINKER /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Essex Riverview Care Center Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year)1925 **Funeral** Months Days Hours 1 □XM 2 □ F 194-12-6319 86 Director Pennsylvania Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once. Baltimore 1 ☐ Yes 2 No Maryland Essex Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 903 Catherine Avenue 21221 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 [XYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 X No Specify: Specify: white 1943/46 3 Nidowed 4 Divorced 16a, Decedent's Usual Occupetion 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Steel Mill Millwright Foreman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ivan Charles Quinter Sr. Lara Anderson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ivan Charles Quinter III (Son) 903 Catherine Avenue Baltimore, Maryland 21221 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Schuylkill Mem. Park 4/6/2012 Schuylkill, Pennsylvania 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bruzdzinski Fuheral Home P.A. 21. Signature of Funeral Service Licenses John W. 1407 Old Eastern Avenue Essex, MAryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 1-10 vanco /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death in the past 12 months? 1 □Yes 2 □ No Month Day Year 5 ☐ Other (specify) Ö 9 Unknown Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 € Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 XNursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident investigation 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🗆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Certified Nurse Practificing stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Natasha Loving 1 Eastern Blvd. Essex, Maryland 21221

Registrar

State

APR 0 4 2012

31. Date filed (Month, Day Year) - ...

0 NATI Baltimore, Maryland 21215-0036 PATient P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 9:33 AM nevo NON MARCH 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death HospilA tim ore If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Hours Min. 1 M 2 NF Country) Yrs. Director LUNC Jsual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits the Maryland Director notified 28a-f 1 Nes 2 No to more ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be 23a Funeral with 560 items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. ò ģ 1 Never Married 2 Married 2 No Yes If Yes, Give Year or Dates 1 Yes 2 No Specify. "natural", Specify: Black Completed 3 Widowed 4 Divorced I Hygiene. other than "natura rent, the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) ulth and Mental Hygien 27 is marked other ti r traumatic event, the Manage ervice Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ orge romas MINIE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Kedmora Ba Himao Department of Health Important: If item 2 any injury or other t other! 20a. Method of Disposition 20b. Place of Disposition (Name of ry, crematory or other place, 1 Burial 2 Cremation 3 Permoval from State 4 Donaties Mollusk 5 Other (Se 22. Name and Address of Facility Funeral Se 4600 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Heart Onset and Death EROlic Physician/ RUSC seas E Alhe disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to for as a consequence of: attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death 1 Yes 2 been signed by the should be detached ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed Yes 2 1 Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? 10 Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural 5 Pending iniury 2 Accident
3 Suicide
4 Homicide Investigation the 6 Could not be within 24 hours after de

To the Funeral Directo

completed filled in by th Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) 31 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) rede SINAI MOSONIA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death MARCH 28, 2012 RIGOBERTO RODRIGUEZ 4:15 am 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE GILCHRIST HOSPICE CENTER TOWSON 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Days Hours 583-96-8308 1 X M 2 🗆 F MARCH 15,1957 PUERTO RICO 55 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 🛚 Yes 2 🗌 No N/ABALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2300 E. MONUMENT STREET 21205 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? 1 Yes 2 XNo Black, White, etc. 1 Never Married 2 Married 1 X Yes 2 No Specify PUERTO RICAN If Yes, Give Year or Dates 3 - Widowed 4 - Divorced Specify. WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) LABORER CONSTRUCTION 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumarne) FELIX RODRIGUEZ **PASCUALA** RAMOS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CARMEN FONSECA/FRIEND 419 W. BELAIR AVENUE, ABERDEEN, MD 21001 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) BAYVIEW CREMATORY 4/2/12 BALTIMORE, MARYLAND Signature of Fundamental Service Licensee LA Address of Facility ER LINCE, FUNERAL HOME LY EASTERN AVENUE, BALTIMORE, MD 21231 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year 4 Pregnant : 1 L Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Physician/ Medical Examiner

Physician/

Medical

Director

Funeral

by

Completed

Be

မ

10a. State

Examiner

Funeral

Director

the Maryland

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

permit. Page 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must hy

Baltimore, Maryland 21215-0036

Examine burial-trar physician the burial Physician/Medical for Completed by icate has Be မ Certificate: filled in by

IF FEMALE:

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

-							1 🗆 Yes 2	No 3 Probably 4 Unknown				
							24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No				
25. Was case referred to medical examiner?	1				26. Place of Death (Che	ck on	ly one)					
1 Yes 2 No	Ho	ospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence (Specify) HOSS: C.										
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigat		28a. Date of injury (Month, Day, Year)	28b. Time of injury	М	28c. Injury at work? 1 ☐ Yes 2 ☐ No		. Describe how injury					
3 Suicide 6 Could no 4 Homicide determine		28e. Place of Injury - At he building, etc. (Specify	ome, farm, stree	t, facto	ory, office	28f	Location (Street and City or Town, State)	Number or Rural Route Number,				
29a. Certifier 1 Certifying P	hysic	an: To the best of my know	ledge, death occ	curred	at the time, date and place,	and c	due to the cause(s) and	d manner as stated.				

Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D0071287

*4105, Balthuere, MD

29d. Date signed (Month, Day, Year,

29c. License number

State Registrar

Cheerles 6701X

3 Certifying Nursa

DHMH 17 Rev 06-2011

within 24 hours a

To the Funeral E

completely filled

Medical

only one) 29b. Signature and title

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 0.3^{Month} 20^{Year}2 28 CARLO A. ROSST 5:01 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 8529 Main Avenue Pasadena Anne Arundel . Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Days Min (Month, Day, Year) 213 26 9457 **Director** 1 X M 2 □ F 82 10 01 1929 Maryland Usual Residence of Decedent 28a-f show 10b. County 10a, State 10c. City. Town or Location 10d. Inside City Limits notified at Director 1 Yes 2 X No MD Anne Arundel Pasadena 0 10e. Street and Number 10f. Zip Code items 23a or ner must be n 10g. Citizen of What Country? Funeral 8529 Main Avenue 21122 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, Examiner Black, White, etc. 0 þ 1 Never Married 2 Married Yes 2 No Yes, Give Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify "natural", Specify Completed 3 Widowed 4 Divorced White Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than, Elementary/Secondary (0-12) College (1-4 or 5+) the Forklift Operator h and Mental Hygier 7 is marked other t General Motors traumatic event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Antoni Rossi Carmela Gliocca Department of Health and Important; If item 27 is n any injury or other traums once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Life-Hellen Cullum 8529 Main Avenue Partner Pasadena, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1

■ Burial 2

□ Cremation 3

□ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem Pk 4/2/2012 Glen Burnie, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility GJ Gonce Funeral Home, 169 Riviera Drive Pasadena, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line ode. Immediate Cause (Final Phyllician/ disease or condition resulting in death) mont Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or injury and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death 5 Other (specify) Day the 8 1 ☐ Yes 2 ☐ 9 ☐ Unknown Unknown signed by 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by No 3 ☐ Probably 4 ☐ Unknown 1 Yes page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an was autopsy performed? certificate has 1 Yes 2 No 25. Was case referred to medical Hospital or Attending Physician: Be 26. Place of Death (Check only one) examiner? Hospital 2000 Other: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Dear 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred Certificate: Natural 2 Accident 5 Pending M Investigation the Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Funeral 29a. Certifier Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one) 29b. Signature and title of certifier 29c. License number D39505

al Dr. Glon Burnie MD. 21061

Registrar

State

0

31. Date filed (Month

30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

205

105/21 F

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For	State o	of Marylan	id / Depa	artment of H	lealth a	and N	/lental Hy	giene		
		1 - State Registrar			Cer	tificate of E	Death			Reg. No. 2	0 2	0387
Physic	ian/	1. Decedent's Name (First, Middle,							2. Date of De Month	ath Day	Year	3. Time of Death
Med	lical	James William	Smith						March			7:35 P ^M
Exami	iner	4a. Facility Name (if not institution, 926 Foxridge La)	-	iber)		4b. City, Town, or Essex	Location o	of Death			ty of Death	
Funera			6. Sex	7. Age (In yrs. In	ast birthday)	If Under 1 Year	If Under:	24 Hrs.	8. Date of Birt			place (State or Foreign
Directo	_	219-80-0472	1 X M 2 □ F	54	Yrs.	Months Days	Hours	Min.	(Month, Da 05/10/	y, Yea <i>r)</i> 1057	Mary.	try)
D WO	٦.	Usual Residence of Decedent 10a. State 10b. County							03/10/	1951		
nylan I-f sh ied a	Director	Maryland Baltin	nore		y, Town or Loc SSEX	cation					1	0d. Inside City Limits 1 ☐ Yes 2XXNo
ne Ma or 288 notif	Dire	10e, Street and Number				10f. Zip Code				10g. Citizen of		
with the 23a c	la l	926 Foxridge Lar	ne				221			U.S.		urys
land 21215-0036 be filed within 72 hours after death with the Maryland ental Hygiene. ked other than "natural", or items 23a or 28a-f show ic event, the Medical Examiner must be notified at	Funeral	11. Marital Status	12. Was Dece	dent Ever in U.S		Vas Decedent of His	spanic Orig	gin? (Spe	cify Yes or No-		ce - Americ	an Indian.
fter d	þ	1 Never Married 2XXMarrie		2XXNo		Yes, specify Cubar		i, Puerto	Rican, etc.)		ack, White, e	etc.
OOS	ted	3 Widowed 4 Divorced	If Yes, Give Year or Da	ites.		Yes 2XXNo				Specif	Wh:	ite
21215-0036 within 72 hours after giene. er than "natural", o , the Medical Exam	Completed	15. Decedent (Specify only highes			(Give k	ent's Usual Occupa		t of worki	ng	16b. Kind of I	Business/Ind	dustry
212 vithin liene. rr tha	ပြွ	Elementary/Secondary (0-12)	College (1-	-4 or 5+)	Capt	NOT use retired)				Fire D	onartr	mont
illed v ill Hyg othe vent,	Be	17. Father's Name (First, Middle, La	ist)		Capti	4111	18. Mothe	er's Name	e (First, Middle,	Maiden Surnan	-	
/lar	은	Raymond Smith					Berr	nadir	ne Zlo	towski		
Maryland 2 should be filed Ith and Mental Hy 27 is marked oth		19a. Informant's Name/Relationshi			19b. Mailin	g Address (Street a	and Numbe	er or Rura	l Route Numbe	r, City or Town,	State, Zip C	iode)
		Beth Smith (Wife	≥)			Foxridge	Lane,	, Ba.	ltimore	, Maryl	and 21	1221
DOFE ge 1 a nt of H : If ite or ott		20a. Method of Disposition XX Burial 2 Cremation	3 🗌 Removal from		lace of Disposemetery, crem	sition (Name of atory or other place	e)	[Date	20c. Location	- City or To	wn, State
Baltimore, Dermit. Page 1 and Department of Hea Important: If item any injury or othe once.		4 Donation 5 Other (Sp		Hol		l Mem. Ga						Maryland
Baitimo permit. Page Department of Important: If any injury or		21. Signature of Funeral Service Lic	censee	Ma.	22	Name and Addres Br 1407 Old	s of Facility UZdZi Easte	inski ern <i>A</i>	i Funera Avenue,	al Home Essex,	P.A.	and 21221
		23a. Part 1. Enter the disease, or of shock, or heart failure. List on	complications that cally one cause on each	aused the deatl	h. Do not ente	r the mode of dying	g, such as o	cardiac o	r respiratory an	rest,		Approximate Interval Between
Physician		Immediate Cause (Final lisease or condition	- met	astat	c Pros	state C	anci	ev				Onset and Death
Medica Examine		resulting in death)	Due to (or as a consequ	ience of):							
	ē	Sequentially list conditions,	b. Due to le	or as a consequ	ionco fr						-	
ted nsit	Examiner	if any leading to immediate cause. Enter Underlying Cause (Disease or injury	L. L. L. L. L. L. L. L. L. L. L. L. L. L	2								
execu in and ial-tra	Ä	that initiated events resulting in death) Last	C. Due to (or as a consequ	ience of):							
6U ate be executed hysician and the burial-transit	edical		d									
oo/c ertificat ding ph		IF FEMALE:										
S, F.O. BOX 68/ ires that the death certific signed by the attending p d be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 Live E		Ideath 3	Ectopic pregnancy	y				ate of delive	·
Box e death the atter hed for	ysic	1 Yes 2 No	4 ☐ Pregr 9 ☐ Unkn	nant at time of d own	leath 5	Other (specify)				M	onth	Day Year
is the set by the detacl	/ Ph	Part II. Other significant condition	s contributing to de	eath but not res	ulting in the ur	derlying cause give	en in Part I.		23e. Did to	bacco use con	tribute to the	e cause of death?
S, T	d by								1 🗆	Yes 2 No	3 Prob	ably 4 D Unknown
ord requ	lete								24a. Was a	an 24b.	Were autop	sy findings available
VICAL KECOFGS, ysician: The law require: s certificate has been si; director, page 2 should t	Completed								autop perfo 1 🗌 Yes	SV	prior to con death?	npletion of cause of
an: Ti an: Ti tificat tor, p	Be C	25. Was case referred to medical	1			26. Pla	ace of Deat	h (Check		2 A No	1 Yes	2
VIII nysici nis cer direc	D B	examiner? 1 \sum Yes 2 \homega No	Hospital:	Inpatient 2	ER/Outpatient	Othe				lence 6 🗆 Oth	ner (Specify)	
OT ng Pt fter th Ineral		27. Manner of Death 1 X Natural 5 □ Pending	28a. Date of	of injury h, Day, Year)	28b. Time of injury	28c. Injury work?	at			ow injury occur		
tendi death. Ior: A the fu	ifica	2 Accident Investiga 3 Suicide 6 Could no	ation			M 1 🗆 '	Yes 2 🗆	No				
DIVISION OT all or Attending PI s after death. Il Director: After th ed in by the funera	Certificate:	4 Homicide determin	28e. Place	of Injury - At ho ig, etc. (Specify)	me, farm, stre)	et, factory, office			28f. Location (S City or Tow	treet and Numb n, State)	per or Rural i	Route Number,
DIVISION Of VITAI RECORDS, F.O. BOX 08/00 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transical process.		29a. Certifier 1 Certifying F	Physician: To the be	est of my knowle	edge, death o	courred at the time	. date and	place an	d due to the ca	use(s) and man	ner as state	d.
n 24 h	Medical	(Check 2 \(\subseteq Medical Ex	aminer: On the basi Nurse Practitioner:	s of examination	and/or investi	gation, in my opinior	n, death occ	curred at	the time, date a	nd place, and du	ue to the caus	se(s) and manner stated.
To the comp		29b. Signature and title of certifier	1 - 1		2.5	29c. License		- P- 101		29d. Date signe	ed (Month, D	ay, Year)
min	-	Lauren /	1. Ma	mo)	MD	DØ4	574	551		3-30	1-12	
O. A.		30. Name and address of person wi						1.5		×> -		
- CI-		Lauven Maure 31. Date filed (Month: Day, Year)		13 V Coold		m 1363	> 1150	Utr	nove, 1	NP ZI	231	
Sta Registi		APR 0.4	2012	ional a dignat	1 %	41						

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 2, Physician/ 2012 Cherryl Szmurlo 6:30 PM Ann Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9470 Brittingham Court Charles La Plata Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 7. Age (In yrs. last birthday) **Funeral** Hours Mir Days 1 🗆 M 2 😾 F Director Michigan 378 64 9391 05/19/1956 55 28a-f shov 10b. County 10d. Inside City Limits aţ 10a. State 10c. City, Town or Location Director must be notified 1 Yes 2 No Maryland Charles La Plata 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 5 Funeral 23a 9470 Brittingham Court United States 20646 or items 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? 1♣ Yes 2 □ No If Yes, Give Year or Dates. 1974-13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Examiner Black, White, etc. 1 Never Married 2 Married þ Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify "natural", Specify: White 1974-00 3 Divorced 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working nould be filed within 72 and Mental Hygiene. life. DO NOT use retired) United States Elementary/Secondary (0-12) College (1-4 or 5+) traumatic event, the Officer Navy Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file h and Mental H **7 is marked o** Hazel Schaible ပ George Lienau 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ye 1 and 2 s t of Health a If item 27 i Paul M. Szmurlo (husband) 9470 Brittingham Court La Plata, Maryland 20646 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 ACremation 3 Removal from State ö Department of smooth Donation 5 🗌 Other (Specify) Bayview Crematory Inc. Apr 4, 2012 Baltimore, Maryland Sia 22. Name and Address of Facility Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Essex Maryland 21221 tal aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death ter the disease, or heart failure. List o se (Final ,Physician Immedia disease o ndition Medical resulting in death) **Examiner** Sequentially list conditions Examine Due to (or as a conse if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Box 68760 the 38 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) for in the past 12 months? Year Month Day Pregnant at time of death Yes 2 No been signed by the a should be detached i 1 ☐ Yes 2 🕻 Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No has page 2 Hospital or Attending Physician: The 24 hours after death. Funeral Director: After this certificate b 1 Yes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28c. Injury at work? 1 \quad Yes 28b. Time of 28d. Describe how injury occurred Certificate: (Month, Day, Year) injury 1 Natural 5 \square Pending 2 🗌 No Investigation Accident filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital within 24 hours a To the Funeral E Medical 29a. Certifier crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the blais of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Configure Fractitioned. To the best provided the provided the time date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitionel ature and title of certifier 29b. Sia 29d. Date signed Month. Day, Year

State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		for State C	of Maryland	·	lealth and Mental Hy	/giene			
		Registrar 1. Decedent's Name (First, Middle, Last)	-	Certificate of D	2 Date of D	Reg. No. 3. Time of Death			
Physic Med		LETITA STEWART			Month 4	Day Year 1910 PM			
Exam		4a. Facility Name (if not institution, give street and num MERCY MEDICAL CEN		4b. City, Town, or	Location of Death	4c. County of Death N/A			
Funera Directo		5. Social Seculity Number 212-34-2180 Usual Residence of Decedent 6. Sex 1 ☐ M 2 🕱 F	7. Age (In yrs. Ia. 77	st birthday) If Under 1 Year Months Days		rth 9. Birthplace (State or Foreign Country) MD			
Maryland Ba-f show	rector	10a. State 10b. County MD Baltimore City	10c. Gity	, Town or Location	Baltimore	10d. Inside City Limits 1 ☐ Yes 2 ☐ No			
with the I ss 23a or 2 nust be no	Funeral Director	10e. Street and Number 623 West Lafayette Avenue		10f. Zip Code	21217	10g. Citizen of What Country? U.S.A.			
laryland 21215-0036 should be filed with 172 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at		11. Marital Status 1	2 □ No e	. 13. Was Decedent of His If Yes, specify Cubar	spanic Origin? (Specify Yes or No	14. Race - American Indian, Black, White, etc. Specify: Black			
Baltimore, Maryland 21215-0036 sernit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. mportant: If item 27 is marked other than "natural", on my injury or other traumatic event, the Medical Exammy injury or other traumatic event, the Medical Exam	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-		16a. Decedent's Usual Occupa (Give kind of work done di life. DO NOT use retired) Home		16b. Kind of Business Industry Own Home			
yland 2 Ild be filed v Mental Hyg larked othe	To Be	17. Father's Name (First, Middle, Last) William C	, Stewart		18. Mother's Name (First, Middle	, Maiden Surname) Nisouri Griffin			
e, Maryl and 2 should I Health and Me tem 27 is marhother traumati		19a. Informant's Name/Relationship (Type, Print) Denise Stewart		19b. Mailing Address (Street at 4 North Carey Str		er, City or Town, State, Zip Code)) 21223			
Baltimore, Marylan permit. Page 1 and 2 should be fi Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evans.		20a. Method of Disposition 1 Ma Burial 2 ☐ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)		ace of Disposition (Name of emetery, crematory or other place King Memorial Park	Date Apr 06, 2012	20c. Location - City or Town, State Windsor Mill, Md.			
Balti permit. Departr Imports any inji		21. Signature of Funeral Service Licensee	es	22. Name and Address Estep Bro 1300 Euta	s of Facility others Funeral Service, I aw Place Baltimore, Md	P. A. 21217			
Physician Medica			caused the death ch line.	ISCHEMIC 1	, such as cardiac or respiratory a	Approximate Interval Between Onset and Death			
Examine		Sequentially list conditions, b. Due to (or as a conseque						
760 ate be executed ohysician and the burial-transit	Examiner	cause. Enrer underlying Cause (Disease or iinjury that initiated events resulting in death) Last C. Due to (or as a consequence of):							
3760 ificate be g physicia as the bu	Medical	d							
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant 23c. If yes, out	nant at time of de	death 3 - Ectopic pregnancy	/	23d. Date of delivery Month Day Year			
Is, P.O lires that the signed by		Part II. Other significant conditions contributing to de	eath but not resu	liting in the underlying cause give		tobacco use contribute to the cause of death? Yes 2 \(\subseteq \text{No} \) 3 \(\subseteq \text{Probably} \) 4 \(\subseteq \text{Unknown} \)			
Division of Vital Records, P.O. ral or Atending Physician: The law requires that the safter death. In Director: After this certificate has been signed by the din by the funeral director, page 2 should be detact	Completed by				24a. Was auto perf	prior to completion of cause of death?			
/ital F sician: Ti s certifical	To Be C	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:	Innationt 2 7	26. Place	ce of Death (Check only one)	2 No 1 Yes 2 No			
on of \number of the of		27. Manner of Death 28a. Date of		28b. Time of 28c. Injury injury work?		how injury occurred			
Division To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completed filled in by the fu	Certificate:	3 Suicide 6 Could not be 28e. Place	of Injury - At honing, etc. (Specify)	ne, farm, street, factory, office	28f. Location (City or To	Street and Number or Rural Route Number, wn, State)			
he Hospit in 24 hour he Funera	Medical	29a. Certifier (Check only one, 3 Certifying Physician: To the base of Certifying Nurse Practionum 2	is of examination.	and/or investigation, in my opinion	death occurred at the time date.	and place, and due to the cause(s) and manner stated			
Not with Con		29b. Signature and title of certifier POTAL MD	-	29c. License	number 30*7-	29d. Date signed (Month, Day, Year) 4 1 2012			
		30. Name and address of person who completed cause DAVID A. VITSKY, MD	342 34	t. PAUL PLACE	BALTIMORE	MD 21202			
Sta Regist	ate rar	31. Date filed (Month, Day, Year) 32. Re	egistrar's Signatu						
DHMH 17 Rev 7/	2009	The state of the s	1. 14	OPIGINAL					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Monti Physician/ 10:00a M Swope Patricia 04 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CARROLL 30 LOCUST STREET APT. 208 WESTMINSTER 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Numb Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. **Funeral Director** 296-32-7875 1 M 2 X F 73 09/25/1938 OHIO Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits must be notified at Director 1 X Yes 2 No CARROLL WESTMINSTER MD 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? Funeral 23a 30 LOCUST STREET APT. 208 21157 U.S.A. filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11 Marital Status Examiner Armed Forces?

1 Yes 2 XNo
If Yes, Give Black, White, etc. ō 1 Never Married 2 Married þ Maryland 21215-0036 1 Yes 2 X No Specify. "natural", WHITE 3 Widowed 4 N Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) TEACHER EDUCATION other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental F permit. Page 1 and 2 should be filk Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve မ FULKERSON HARRY WILLIS SWOPE GRACE MARIE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 6010 RIVER MEADOWS DRIVE, COLUMBIA, MD 21045 CHRISTINA BIRD-WALKER Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗆 Burial 2 🏋 remation 3 🗆 Removal from State BAYVIEW CREMATORY 4/3/12 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
LILLY & ZEILER INC.
1901 EASTERN AVENUE Signature of Fu and 3 rvice Licensee FUNERAL HOME BALTIMORE, MD 21231 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CAD 13-SC disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate Cause (Disease or injury burial-trar and that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical The law requires that the death certificate be P.O. Box 68760 use as the the attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown detached for Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown Division of Vital Records, 1 Yes peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate has filled in by the funeral director, page 2 performe 1 Yes 2 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) Hospital: 2 No မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 Natural 2 Accident injury 5 Pending Investigation 24 hours after deatl Funeral Director. 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

The pasis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Ctitioner: To the best of my browledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the Certifying Nurse Practitioner: To the best of my within 2 To the F 29b. Signature and title of cert 29d. Date signed (Month, Day, Year) of death (Item 23a) (Type, Print) 30. Name and address of p Depar

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 20 12 Physician/ Marian Sing sky 2:15 P March Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE SEASONS HOSPICE @ NORTHWEST HOSPITAL RANDALLSTOWN If Under 1 Year If Under 24 Hrs 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** Director 213-26-8558 1 □ M 2 🏻 F 83 01/31/1929 MD Usual Residence of Deceden or items 23a or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-i sho. 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Funeral Director 1 Yes 2 X No MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? 4502 MARYKNOLL ROAD 21208 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: 3 X Widowed 4 □ Divorced WHITE Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) traumatic event, the ACCOUNTANT HOUSING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ ELI ISADORE SCHWARTZ FLORENCE KARU 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MICHELLE AMIRAULT/DAUGHTER 118 WALNUT STREET, HERMANN, MO 65041 20a. Method of Disposition
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of h Important: If ite any injury or ot once. ANSHE EMUNAH^{her place)} AITZ CHAIM BALTIMORE, MD 04/01/2012 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the di ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final ovanan (ancer Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Examiner Due to locas e nonsequance offi To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year Pregnant at time of death 5 Other (specify) 2 No 1 ☐ Yes 2 ☐ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy 1 Yes 2 No I Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 4 Nursing Home 5 Residence 6 Tother specify Hospital: 1 ☐ Yes 2 ☑ No Other: ၉ 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work?
1 \(\sum \) Yes 2 \(\sum \) No iniury 5 Pending Accident Investigation Director: ⊒ Acciden ⊒ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State)

within 24 hours a To the Funeral C

Medical

29a, Certifier (Check

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

MS Raj cysalaseMD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N SKYMAIHEM I) 7835 Smith

32. Registrar's Signature

DHMH 17 Rev 06-2011

State Registrar Smith A

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

00057465

29d. Date signed (Month, Day, Year)

Balhmone MD 217 09

3/30/12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	ı	,	For State Registrar	State of M	arylan	•	artment rtificate			ind Me		giene Reg. No.	2010)	0201	
F	Physicia /Medic	an	1. Decedent's Name (First, Middle, La MARCIA C						2. Date of Death Month RTZ Mirret					Day Year 29, 2012 1:45 AM		
-	Examin	er	4a. Facility Name (If not institution, giv	EW HOME			BA	ALTI	Location of MORE If Under 2		O. Data of Bid	4c. (County of Death			
L	Funeral Director		5. Social Security Number 6. S 215-10-6391 Usual Residence of Decedent	5ex 1 □ M 2 X F	95	last birthday) Yrs.	If Under 1 Months	Days	Hours	Min.	8. Date of Birt (Month, Da 08/04	y, Year)	Cot	intry)	e or Foreign	
Maryland a-f show	Maryland a-f show iffied at		10a. State 10b. County MD N/A		10c. City	y, Town or Lo									City Limits es 2 ☐ No	
	with the a or 28 be no	Director	10e. Street and Number	DO 4 D			10f. Zip (200			10g. Citiz	zen of What Co	untry?		
Ind 212150036 be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ours after death ral", or items 23 Examiner must	by Funeral	3209 LABYRINTH 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces?			Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 XNo Specify:					USA 14. Race - American Indian, Black, White, etc. Specify: WHITE				
	Completed	15. Decedent's E (Specify only highest gr.		5+)	(Give life.	dent's Usual kind of work DO NOT use LESPER	k done di e retired)	urina most	of workin	g	16b. Kir	nd of Business/I	ndustry			
	should be filed on Mental Hygin marked other matic event, ti	To Be C	17. Father's Name (First, Middle, Last)					18. Mother	r's Name	(First, Middle,	Maiden	Surname)			
Maryland			JAMES 19a. Informant's Name/Relationship	(Time Print)	COH		na Address /	(Street a	EVA		Boute Numb	er City o	CI r Town, State, Z	ROOK		
	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		SUSAN SCHWARTZ			1.	,	•					LTIMORE		21215	
Baltimore,	00 0 1		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Speci	Removal from State	,	Place of Disponent Cemetery, created ANSHE CHAIM	matorý or oti EMIJNAF	her place I AT'	ヤク・		/2012		cation - City or			
Balt	permit, Pag Department Important: I any Injury o		21. Signature Funeral-Service Lice	ittlen		8	2. Name and 900 RE	Addres	ERSTO	WN R	OAD, P	IKES	BROS.	1D 21	.208	
3	Physician /Medical		23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	pplications that cause one cause on each I a. COROI Due to (or as	ine. UAR	YA						rrest,		Approxir Interval Onset a	nate Between nd Death	
Examiner	#2-	ical Examiner	Sequentially list conditions, If any leading to include cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): C. Due to (or as a consequence of):													
Division or Vital Records, P.O. Box 687	ath certific aftending p for use as	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a	2 Feta	ideath 3	⊒Ectopic pre ⊒ Other (spe					2	23d. Date of del Month	ivery Day	Year	
rds, P.	w requires that the de been signed by the should be detached	b	Part II. Other significant conditions	ignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to												
Recor The law req ate has beer	The law recate has bee page 2 shou	Completed									24a. Was auto perfo		24b. Were au prior to death?	completion (gs available of cause of	
Vita	sician: Th certificate rector, pag	To Be	25. Was case referred to medical examiner?	Hospital:		150/0		Δ Othe			(Check only o					
on or ding Physi	nding Physician: The lar th. r: After this certificate has e funeral director, page 2		1 Yes 2 No 27. Manner of Death 1 November 1 Pending 2 Accident Investigation	28a. Date of Inj (Month, D	ury	28b. Time of Injury		Bc. Injury Work	4 J24-14U	2	ne 5∐ Resi !8d. Describe		6 ☐Other (Speny occurred	cify)		
Divis	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	Zoe. Flace Ulik	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)			2	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	ne Hospita n 24 hours ne Funeral	Medical (se(s)					
	To the I within 2. To the I complet	ž	29b. Signature and title of certifier					. License					te signed (Mont		r)	
									03/29/2012							
	5	1	30. Name and address of person who	completed cause of	death (Iter	n 23a) (Гуре, W, В	ELV EX	XLE	AVE	BA	LTIMOR	E, M	D 212	15		
	。Sta Registi	_	GIZAIN WOLDETTIV 31. Date filed (Month, Day, Year) APR 0 4 2012	32. Regis	trar's Signa	face	,			. 1011	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,,,,	, 00			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

			State of Maryland	/ Depa		Health and	Mental Hygie	ene	10393			
	_		Registrar 1. Decedent's Name (First, Middle, Last)	Oei		Death	2. Date of Death	J. No. U	3. Time of Death			
	Physici	an	the second secon	Month	Month Day Year							
	/Medic	ai	JANNIE MAE SCOTT		4h Oih Tour	or Location of Dea		MARCH 22, 2012 3:				
	Examin	er	4a. Facility Name (If not institution, give street and number)				un	4c. County of Dear	и			
			FUTURECARE NURSING CENTER 5. Social Security Number 6. Sex 7. Age (In yrs. la:	at hirthday		IMORE	8 Date of Birth	N/A				
	Funeral		1 M 2 XE	Vra	Months Days			Birth Day, Year) 9. Birthplace (State or Foreign Country) MARYLAND				
-	Director		215-28-5769 79 Usual Residence of Decedent	,			2-2-19) I MAI	CLAND			
	'land			Town or Lo	ocation		· · · · · · · · · · · · · · · · · · ·		10d. Inside City Limits			
	Man	tor	MD. N/A E	BALTIM	(ORE				1 ∰Yes 2 ☐ No			
	128g	al Director	10e. Street and Number	/21LD I I I	10f. Zip Code		109	g. Citizen of What Co	ountry?			
	38 o 38 o 38 o 38 o 38 o 38 o 38 o 38 o		558 ORCHARD ST.		2120	01		USA				
	me 2	Funeral	11. Marital Status 12. Was Decedent Ever in U.S.	. 13.			Specify Yes or No- rto Rican, etc.)	14. Race - Ame				
0	after or Ite	Ful	Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes, Give	1 □Yes 2∑ No		Black, Whit	e, etc.					
2-003g	ours i.e.	by	3 ₩idowed 4 Divorced Year or Dates:		Specify:	BLACK						
2	in 72 hours after death with the Maryland "naturel", or Iteme 23a or 28a-f show realizal Examiner must be notitied at	etec	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occu	upation e during most of wo red)	orking 16	6b. Kind of Business	/Industry			
7	d within giena. Ir then "I	Completed	Elementary/Secondary (0-12) College (1-4or 5+)									
N	ygier ygier tartt	Ö	-120-	NUE	RSING AS:			HEALTHO	CARE			
	tal H doth	To Be	17. Father's Name (First, Middle, Last)					st, Middle, Maiden Sumame)				
<u> </u>	2 should be and Mental ie markad aumatic ev		JAMES WILSON			1	E RICE	RICE Route Number, City or Town, State, Zip Code)				
Jac	s 1 and 2 should f Health and Mer item 27 ie marka other traumatic		19a. Informant's Name/Relationship (Type, Print) FRANCINE BAKER (DAUGHTER)		,							
ອ໌ ອ໌	and fealth m 27 her t				osition (Name of	D SI. DAL	TIMORE, MA	oc. Location - City or	21201			
	96 ≃ 5		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State	netery, crei	matory or other pl	.						
			' 4 □Donation 5 □ Other (Specify) METF		EMATORY		9-2012 BA					
Sal	parmit. Departr Importe any inju		21. Signature of Funeral Service Licensee DORETHA HECTO				ILLIPS FU		•			
_	20 E # 0		x nech				-		Approximate			
			23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.	lisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory an ilure. List only one cause on each line.								
F	hysician		Immediate Cause (Final disease or condition Resonation Fulne									
	/Medical Examiner		resulting in death) Due to (or as a conseque	ence of):		0 0						
		<u>.</u>	Sequentially list conditions, b	Obst	suctive Pulmonon &			breare				
	sit sit	Examiner	if any, leading to anneatiate cause. Enter Inderlying Cause (Disease or injury	C (a.	· -	11-0 4-	Vail a					
	be executed ician and burial-transit	хап	that initiated events resulting in death) Last Due to (or as a conseque	ence of):	p/me_	2000	Tronge					
Ď.	e be executed sician and burial-transit	calE	Jement	,								
200	leath certificate i attending physi i for use as the b		d. Straw	<u> </u>								
X	death certificate e attending phys id for use as the	Physician/Medi	IF FEMALE: 23c. If yes, outcome of pregnance	cv				23d. Date of de	liven			
POX	atten for u	cian	in the past 12 months?	teath 3[□Ectopic pregnan □ Other (specify)	су		Month	Day Year			
j.	0 0 0	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown		_ Carior (opoony)							
J.	law requires that the de as been signed by the a 2 should be detached f		Part II. Other significant conditions contributing to death but not result	23e. Did toba	3e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 □ No 3 □ Probably 4 □ Unknown							
ecoras,	sign sign d be	d by	Penihilan mass	1 ☐ Yes								
Ö	w require been sign	Completed	A .	24a. Was an	fas an 24b. Were autopsy findings available							
	Tha lav	E E	Manna	autopsy	autopsy prior to completion of cause of death?							
		o Be Col	Of Mississipping and the modified	-			1 Yes 2		5 2□ No			
 			25. Was case referred to medical examiner? 1 □ Yes 2 □ No Hospital: 1 □ Inpatient 2 □ E	ath (Check only one								
0	Phys ratdi	-	27. Manner of Death 28a. Date of Injury 2	7	☐ Residence 6 ☐ Other (Specify) scribe how injury occurred							
0	ding P	Certification;	1 ☐Natural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation	ury at 'ork? □ Yes 2 □ No								
DIVISION	death death ctor: y the	fica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At hom	ne, farm, st	reet, factory, office	θ		et and Number or R	ural Route Number,			
2	after Dire	erti	4 Homicide building, etc. (Specify)		, , , , , , , , , , , , , , , , , , , ,		City or Town,	State)				
	ne Hospitel or Attending P n 24 hours after death. ha Funerel Di octor: After t detely filled in by the funera	aC	29a. Certifier 1 Certifying Physician: To the best of my know									
)	8 Fu	ledical	(Check only 2 Medical Examiner: On the basis of examination and manner stated.	on and/or in	vestigation, in my	opinion, death occ	curred at the time, dat	e and place, and du	a to the cause(s)			
	To the h within 2 To the l	Me	29b. Signature and title of certifier		29c. Lice	nse number	29	d. Date signed (Mon				
	. , , , ,		Dave 40		D	31464		3/25/17	3/29/12			
	. 1		30. Name and address of person who completed cause of death (Item :	23a) (Type.	Print)	77-97						
	11		SHOA113 A. HASHMI MD. 821 N.	EUTI	AW ST	Shite 30	of, BALT	imore m	ID 2/201			
	Sta	ite	31. Date filed (Month, Day, Year) 32. Registrar's Signatu	ıre								
	Regist	ar	APR 0 4 2012 June 8. 4	back	1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 12:45PM 10 maMedical 2010 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death 4604 airview altimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 7. Age (In vrs. last birthday **Funeral** 9. Birthplace (State or Foreign 212-22-Months 1 X M 2 🗆 F Director Country) Usual Residence of Decedent or 28a-f show 10a. State with the Maryland be notified at 10c. City, Town or Location Director 10d. Inside City/Limits 1 Nes 2 No Himore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral mus 23a 21216 permit. Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give "natural", or iten ledical Examiner n 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 9 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Completed 3 Widowed 4 Divorced Army Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. Elementary/Seconday (0-12) College 1-4 or 5+) Manage Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ent of Health and Mental H it: If item 27 is marked ot y or other traumatic even မ Mary iomas Moone 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) cque MD 21208 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State Important: I any injury o 4 Donation 5 Other Speciff 21. Signal of Funeral Service Licens He ά 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Intarction Onset and Death Myocardial Ph_sician/ disease or condition resulting in death) Medical Examiner demi ears coertially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran that initiated events resulting in death) Last nding physician and Due to (or as a consequence of): Physician/Medical P.O. Box 68760 use as IF FEMALE yes, outcome of pregnancy
Live Birth 2 Tetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) atter Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No jo Pregnant at time of death Dav Year signed by the al Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 🏋 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy certificate 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical filled in by the funeral director, To Be 26. Place of Death (Check only one) 2 🗆 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral director. 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural work?
1 \(\subseteq \text{ Yes} \quad 2 \subseteq \text{ No} \) 5 Pending injury Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 V Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. R153298 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) North greene Baltimore mo 2180 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Stephanie 3 01 1730 Medical a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death of Maryland Medical CH Baltimore Universit 6. Sex If Under 1 Year I If Under 24 Hrs 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Director** 1 □ M 2 🗹 F Usual Residence of Decedent 1961 or 28a-f show notified at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Baltimore 1 Yes 2 No OSe 10e. Street and Number ō r items 23a or iner must be r 10g. Citizen of What Country? Funeral 0000 should be filed within 72 hours after death and Mental Hygiene. is marked other than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. permit. Page 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates. Maryland 21215-0036 1 ☐ Yes 2 ☑No Specify: Completed 3 Widowed 4 Divorced Bla 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life_DO NOT use retired) whed /Secondary (0-12) College (1-4 or 5+) Be Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ Holman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Acenses 22 Name and Address of Facility S Hone 201 OY 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Approximate Interval Between nset and Death Physician/ penetruting disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner NCAL EXAMINER Due to (or as a consequence of) CENTIFICATION APPROVED BY ME the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events attending physician and Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Day Pregnant at time of death Unknown Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by cate has been sig Completed 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24a. Was an Were autopsy findings available autopsy prior to completion of cause of death? performed? certificate 2 ANO 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) မ Other: 1 🔀 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 Nursing Home 5 Residence 6 Other (Specify 24 hours after death. Funeral Director: After this Certificate: 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 🛣 No 03,27,2012 Knite wound, x 8, chest self inflicted Accident Investigation 6 Could not be 1200 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Ryral Route Number 4 Homicide determined City or Town, State) home 113 Medical 29a. Certifier 🔾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check To the F 3 🗆 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certi 29d. Date signed (Month, Day, Year) 0101242629 28, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suvatne Baltimore South Street 21201 Jimmy 22 Greene 31. Date filed (Month, Day, Year) 32. Registrar's Signatu State APR 0 4 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Emilv Tompkins Taliaferro April 2. 2012 11:30 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Roland Park Place Baltimore N/A Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days **Director** 213-22-6948 1 🗆 M 2 💢 F 82 5/28/1929 Maryland Usual Residence of Decedent show 10c. City, Town or Location be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director or 28a-f Maryland N/A Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? pe ms 23a must be Funeral 830 W. 40th Street rm 2007 21211 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 0 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: If Yes Give "natural" Completed 3 Widowed 4X Divorced Specify: White Year or Dates 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) event, the Artist Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Marked o ပ Raymond S. Tompkins Marie Lanning and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tina Maclary Page 1 and 2 / daughter 17 Vassar Drive Newark, Delaware 19711 item 2 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Department of H Important: If ite any injury or ot once, 20c. Location - City or Town, State 4 Donation 5 Other (Specify) Hilltop Serv. Corp. 4/4/2012 Towson, Maryland 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service Licer 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ INFAYET disease or condition resulting in death) ementia Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or injury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Pregnant at time of death Month 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? VASCULAY ACCIDENT Cerebral Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown FI BVILLATION ATTIAL 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 2 No 1 Tes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Yes 2 ☐ No ျ Other: 1 Inpatient 2 ER/Outpatient 3 I Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation within 24 hours after death

To the Funeral Director: /
completely filled in by the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

Registrar DHMH 17 Rev 06-2011 29a. Certifier (Check

only one) 29b. Signature

30. Name and address of persor

MY-

and title of certifie

DOW

who completed cause of death (Item 23a) (Type, Print)

m.D.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

35102

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

5901 North CHAYLES

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 27 Year 12 Month 2AMOHT, ISABELLE 3 21:05 M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death MERCY MEDICAL CENTER N/A BALTIMORE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 💢 F Months 213-30-4182 **Director** 76 Yrs Marvland Usual Residence of Decedent 28a-f show 10a. State notified at 10c. City, Town or Location 10d. Inside City Limits Director N/A Baltimore MD 1X Yes 2 No 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? "natural", or items 23a o Funeral with U.S.A. 901 Cherryhill Rd. 21225 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Was Deceud... Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. Specify: Black Completed 3 Widowed 4 Divorced er than "natura , the Medical E 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry St. Joseph (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Nurse Technician Hospital <u>2th grade</u> is marked other Be . Page 1 and 2 should be filed ment of Health and Mental Hy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic en one. Margie Thorton Elmer Finney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 1361 Spellman Rd., Baltimore, MD 21225 Barbara Parker(sister) 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) on-site Crematory 03/30/12 Baltimore, MD of Funeral Service Licensee 21. Signatura Josephadrs of Brown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ LUNG CANCER METASTATIC disease or condition MONTHS Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Cause (Disease or iinjury the burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of): signed by the attending physician d be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed this certificate 1 🗆 Yes 2 🗆 No 1 Yes 2 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Tes 2 X No Other: Certificate: To 1 Nation 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funeral 1 Natural injury 5 Pending work 1 Yes 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the l within 2 To the F only one)

State Registrar

29b. Signature and title of certifier

RUSHAN 31. Date filed (Month. Day.

PATEL

Year

APR 0 4

til

345

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2012

DHMH 17 Rev 7/2009

PL.

ST. PAUL

Registrar's Signature

P27390

BALTIMORE, MD 21201

29d. Date signed (Month, Day, Year)

2012

3/ 27

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month OHN WIATROWSKI 2012 2:25 April Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Ivy Hall Geriatrics Baltimore 8. Date of Birth (Month, Day, Year) 09/18/1940 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** Days Months Hours 1 XM 2 □ F Director 246-12-4578 71 Maryland Usual Residence of Decedent 28a-f shov 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 X Yes 2 No MD **Baltimore** 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 1300 Windlass Drive 21220 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc þ "natural", or 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify. Completed 3 Widowed 4 Divorced Year or Dates White Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Department of health and Mental Hygiene. Important. If item 27 is marked other than 'any injury or other traumatic event, the Meagure. Elementary/Secondary (0-12) College (1-4 or 5+) 10 Roofer Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Edward Wiatrowski Margaret Combs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia W. Wheeler / Sister 11032 Finchley Place, Orlando, MD 32837 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 4/3/2012 Beltsville, MD Signature of Funeral Service Licenses 22. Name and Address of Facility Dorota Marshall Jouche Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Examine ri any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence or) burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23h. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 2 No Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? obstructive Dulmonary 0126as4 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 page 1 Yes 2 No completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify, Manner of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No after death. Director: Aff Investigation Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I only one) Signa 29d. Date signed (Month. Dav. Year) Printy MOZIAOZ

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year

APR 0 4 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For Amend Item 26 State of Maryland / Department of Health and Mental Hygiene Registrar Certificate of Death Reg. No. Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Month 03 Physician/ Day CHING TANG WEI 943 M 24 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Bethesda Suburban Hospital Social Security Number If Under 1 Year If Under 24 Hrs. 8, Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Hours Min 03/08/1923 101-38-0035 89 Director 1 M 2 🗆 F China Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits at Director notified MD Montgomery Bethesda 1 Yes 2 No 10g Citizen of What Country? 10e. Street and Number 10f. Zip Code 20814 0 the Medical Examiner must be 6803 Fairfax Rd. Apt. 110 23a 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. ö þ 1 Never Married 2 Married Specify: Asian Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. "natural", 3 X Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working should be filed within 72. In and Mental Hygiene. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Food Industry Cook other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Unk Unk 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18500~Bay~Leaf~Way~Germantown,~MD~2087419a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh.
Department of Health an
Important: If item 27 is any injury or other Kuang Wei/Son 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Mar Pat 29. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Silver Spring, MD 2012 Gate of Heaven 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fack pp Funeral & Cremation Services 21. Signature of Funeral Service Licensee Rebeaco 933 Gist Ave. Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between ATHLEROSCEROTIC CARDIOVASCURAL DISEASE Immediate Cause (Final Onset and Death Ph. sician disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 the attending phy use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Year Month Day 9 Unknown signed by i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CHRONIC ANEMIA 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s performed Yes 2 death?
1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA ည 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No o the Hospital or Attendir ithin 24 hours after death. o the Funeral Director: Af ompletely filled in by the fu 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D0037314 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8600 OLD GEURGETOWN RD. BETHESDA FRED ND 20814

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

APR 0 4 2012

THAG

CHES

/32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 2012 Month 2 Welsh 1729 len. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Ummo Baltimore If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Hours Min (Month, Day, Year) 215845738 **Director** 1**X** M 2 □ F 46 Yrs. 10-11-Washington DC show 10a. State notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f 1 Tes 2 No Maryland Harford Abingdon 10e. Street and Number 10f. Zip Code ems 23a or must be r ò 10g. Citizen of What Country? Funeral 21009 USA 3836 Copper Beach Drive items ? ial Hygiene.
of other than "natural", or items event, the Medical Examiner m 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 X Never Married 2 Married Yes 2 K No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Completed 3 Widowed 4 Divorced Specify: white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) disabled 12 event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I ၉ permit. Page 1 and 2 should be Department of Health and Men Important; if item 27 is marke any injury or other traumatic once. Alice Marie Welsh traumatic Robert Lee White 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 110 W. BelAir, Avenue, Aberdeen, MD 21001 Dr. Robert Clipp (Friend) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 4/4/2012 West Chester, PA Ferris & Company 21. Signature of Funeral Service Licensee ^{22. Name and Address of Facility} Tarring—Cargo Funeral Home, P.A Aberdeen, Maryland 21001 UN 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final nset and Death Preumonie Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, it can be each of to man solicito cause. Enter Underlying Examiner attending physician and I for use as the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 3 ☐ Ectopic pregna 5 ☐ Other (specify) Month Day 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 has autopsy performed? death? certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 🗌 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 Yes 2 🗌 No မ Inpatient 2 - ER/Outpatient 3 - DOA Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at Certificate: 28d. Describe how injury occurred ☐ Natural 5 Pending 19 Padestuan Struck hours after death -23.2012 2X No 2 Accident 3 Suicide filled in by the Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Boulevasdana Roice 54 within 24 hours a To the Funeral L Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier npletely (Check S 🖰 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signa 4-2-2012 101386 VECKEL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22. S. Greene St. Baltimore MD 21201 MD Luec Stephanic

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ \mathbf{A}^{M} Chung Yiu Yu 2012 1:00 March Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Suburban Hospital Bethesda Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Age (In yrs. last birthday) 8. Date of Birth Days 1 M 2 D F Macau **Director** 218-02-0666 79 04/08/1932 28a-f show at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director must be notified 1 XYes 2 No MD Montgomery Gaithersburg 0 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 23a Funeral 55 Bralan Court 20877 72 hours after death or items "natural", or item ledical Examiner m 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ Yes 2 XNo Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: Specify: Completed 3 🗆 Widowed 4 🗆 Divorced Year or Dates Asian the Medical 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) during most of working is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. Civil Engineering 12 Food Service 2 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic Wo-Chun Yu Hing-Wan Lau 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Annie Tse Yu / Wife 55 Bralan Court, Gaithersburg, MD 20877 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 Burial 2 XCremation 3 Removal from State 4 Donation 5 Other (Specify) Atlantic Crematory 3/31/2012 Glen Burnie, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a Part 1 Enter the disease or Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Non-traumatic Intacranial Hemmorha e disease or condition Medical Examiner resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) burial-transi Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last Physician/Medical that the death certificate be the use as attending IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery Box 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? page 2 should be detached for Month Day Year Pregnant at time of death 9 Unknown 9 Unknown P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sign 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4. Yunknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy O performed? death? 2 **N**0 0 Yes 2 XNo Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) 0 Hospital 1 X Yes 2 ☐ No 2 1 Xinpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) the funeral 27. Manner of Death 1 Natural 28b. Time of 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28d. Describe how injury occurred injury 5 Pending Accident N 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 \square Homicide filled in by determined City or Town, State) T 18 Medical Xertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Melissa Means, M.D. 8600 Old Georgetown Road, Bethesda, MD 20814 State Registrar

Komanda lee 12-02473 YOUNG UNKUNK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

NIK ONK		5[A] 1- For State Registrar	e or Maryland	-	artment of rtificate of	**	na ivientai		Reg. No. 20	12 1040
Physicia	an/	1. Decedent's Name (First, Middle,L	ast)				-	2. Date of Dea	ath	3. Time of Death
Medical Exami	ner	Romanda Young						Month March 27		1820 hrs
		4a. Facility Name (if not institution, of Harbor Hospital	give street and number)		4	b. City, Town, o Baltimore	r Location of D	eatn	4c. County of I	Death
Funeral		5. Social Security Number 6.	Sex 7. Age	e (In yrs. i	ast birthday)	If Under 1 Ye			irth (MM/DD/YYYY)	9. Birthplace (State or oreign
Director		218-88-6998 1	XM 2 F		41 Yrs.	Months Day	ys Hours	Min. 11/23	/1970	Country) MD
any		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Location	on				10d, Inside City Limits
. .	_	MD N	I/A			Ba	ltimor	· e		1 X Yes 2 No
Maryland 28a-f show d at once.	Director	10e. Street and Number	,,			10f. Zip Code			10g. Citizen of What	Country?
h the N 3a or		219 Bishop Av					1225		U.S.	
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28s-f sho natic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 Never Married 2 Marrie		_				(Specify Yes or No erto Rican, etc.)	14. Race - A White, e	American Indian, Black, etc.
fter de			1 Yes 23 ed If Yes, Give Yeer	∑ No	1	Yes 2 X No	o s <i>pecify:</i>		Specify: I	Black
lours a	ğ Ş	15. Decedent's Education (Specify	only highest grade com	pleted)		's Usual Occupa			16b. Kind of Busin	ess/Industry
5-0036 led within 72 hours afte Hygiene. I other than "natural", the Medical Examine:	Completed	Elementary/Secondary (0-12)	College (1-4 or 5	i+)	Brick		. 20 110 1 400		Dhoonis	. Duilding
5-003 lied withi Hygiene. d other tt	ē	12th Grade 17. Father's Name (First, Middle, La	st)		DITCK	Tayer	18.Mother's N	ame (First, Middle,		k Building
21215-0036 wid be filed within 7 Mental Hygiene, marked other than	æ	David Young J						a Heard		
MD 2. d 2 should th and M n 27 is m numatic c	-1	19a. Informant's Name/Relationship			1.0	•				State, Zip Code
e, M and 2 lealth item 2 traum	ł	Iletha White(m 20a. Method of Disposition			Place of Disposit	tion (Name of ce		Date Date	len Burr 20c. Location - Ci	
imore, MD 2121 Pages 1 and 2 should be fi nent of Health and Mental isant: If item 27 is marked or other traumatic event,		1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other Speci		i.e	crematory or oth ng Memo		0	4/04/12	Baltimo	ore.MD
Baltimore, MD 2 permit. Pages I and 2 shoul Department of Health and M Important: If item 27 is millingry or other traumantic.		21. Signature of Funeral Service Lice		11					uneral H Baltimon	
	1	23a. Part I. Enter the disease, or cor	V.Will	la.						ce, MD 21217
Physician Medical		failure. List only one cause on	each line.			e mode or dying	, such as cardia	ocorrespiratory arr	est, shock, or heart	Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Multiple Sharp F Due to (or as a conse							
	اي	Sequentially list conditions,	b. Due to (or as a conse		٤١.					
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Σ							
ited J ansit	Exa	events resulting in death) Last	Due to (or as a conse	quence o	f):					
60, ate be executed bhysician and te burial - transit	Medical	UNPENDED	AMENDED							
760, icate be physic the buri	Me.	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcom	e of preg					23d. Date of del	
Box 6876: death certificat the attending physical for use as the	cian	past 12 months?	1 Live birth 4 Pregnant at	ime of de		aldeath 3 er (Specify)	Ectopic pre	gnancy	Month	Day Year
BO)	Physician/	1 Yes 2 No 9 Unknow	9 Unknown					I as sim		
Records, P.O. Box 68760, The law requires that the death certificate be executed ricate has been signed by the attending physician and page 2 should be detached for use as the burial - trans	ρ	Part ii. Other significant conditions	contributing to death	but not re	esulting in the ur	derlying cause	given in Part I.			e to the cause of death? Probably 4 Unknown
rds, require been significantly be	Completed							24a. Was	an 24b. Wer	e autopsy findings available
of Vital Records, of Physician: The law requirement the this certificate has been so neral director, page 2 should be	d			-				_ autop perfor 1 ✓ Yes	rmed? deat	r to completion of cause of h? Yes 2 No
1 of Vital Recing Physician: The B	Be	25. Was case referred to medical	=24(5e(e=e) =	LJ			e of Death (Che		2 10 1	165 2 100
of Vital ig Physician: the this certif		examiner? 1 ✓ Yes 2 No			ER/Outpatient			rsing Home 5		Other:
n of ding Pl h. After		27. Manner of Death 1 Natural 5 Pending	28a. Date of Injur FOUND: Day,Ye	y ear)	28b. Time of In	· _ ·	ıry at Work? Yes 2 ✔ No	28d. Describe i Subject was	how injury occurred assulted	
Division al or Attendi rs after death. al Director: A	icati	2 Accident Investiga	28e Place of Ini	ury - At ho	1748 hrs ome, farm, street			28f. Location (\$	Street and Number o	r Rural Route Number, City
Divis pital or At ours after d teral Direct	Certification:	3 Suicide 6 Could no determin		al Stree	et			or Town, S outside of 304	state) 1 Berlin Avenue, B	altimore, MD
Division To the Hospital or Attendin within 24 hours after death. To the Funeral Director: A completely filled in by the fu		29a. Certifier (Check only one) 2 Medical Examin	cian: To the best of my	knowled	ge, death occurre	ed at the time, d	ate and place,	and due to the caus	se(s) and manner as	stated.
To th withi: To th	Medical	29b. Signature and title of certifier	er: On the basis of exam and manner stated.	mation at	naroi investigatio	29c. Licens		at the time, date	29d. Date signed	
	-	his live.	~>			O.C.			March 28, 20	
	-	30. Name and address of person who	completed cause of de	ath (Item	23a)				l	
			Medical Examiner			Street, Bal	timore, MD	21223		
St Regist		31. Date filed (Month, Day, Year) APR 0 4 20	12 Régistrar	s Signatu	back	1				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month moria, C M Zurita. P:03 neurch Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Be HIMOre University of Manyland Medical Center If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days 385-17-4545 1 □ M 2 🏋 F Director FEB 3, 1963 Mexico 49 Usual Residence of Decedent 28a-f show 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 🗆 Yes 2 🗓 No New Castle Delaware Wilmington 10e. Street and Number 10f. Zip Code 5 10g. Citizen of What Country? Funeral 23a 3806 Nancy Avenue, Dunlinden Acres 19808 Mexico death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. 9 þ 1 Never Married 2 X Married 2 X No 1 ☐ Yes If Yes, Give within 72 hours after Baltimore, Maryland 21215-0036 1 XYes 2 □ No Specify: Mexican Specify: White 'natural", 3 Widowed 4 Divorced Completed Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Mushroom Worker Agriculture Be Page 1 and 2 should be filed went of Health and Mental Hygant: If item 27 is marked oth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Emelia Juarez Jose Surita 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3806 Nancy Avenue, Dunlinden Acres, Wilmington, DE 19808 Gabriel Gonzalez / Husband 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of Important: If it any injury or o 4 ☐ Donation 5 ☐ Other (Specify) Juan Lucas, GIO, Mexico Cementerio Juan Lucas permit. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Kuzo & Grieco Funeral Home 250 West State Street, Kennett Square, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Pneumonia Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated support or injury) Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death the detached 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed I þ 1 ☐ Yes 2 🗹 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, or Attending Physician: The law requires Ence stage liver disease Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has page 2 performed? Yes 2 No 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 **V** No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Man er of Death Certificate: 28c. Injury at work? 28a. Date of injury 28b. Time of 28d. Describe how injury occurred Director; After (Month, Day, Year) Natural 5 Pending 1 Yes 2 No Accident Investigation filled in by the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

State Registrar

Medical

29a. Certifier

29b. Signature and title of certifier

31. Date filed (Month; Day, Year)

Hospital 24 hours

To the within 2

MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Norsworthy, 22 south Greene

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License numbe

P24354

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

Meurch 30, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mary Patricia Neese Ashby March 2012 Рм 8:39 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Deatl 4c. County of Death Frederick Frederick Memorial Hospital Frederick | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | May 1 1 3, 1940 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 224-54-4602 1 □ M 2 🛣 F New York Director Usual Residence of Decedent or 28a-f show notified at 10b. County 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.
item 27 is marked other than "natural", or items 23a or 28a-f shou other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Frederick Mt. Airy 1 Yes XX No 10f. Zip Code 21771 10e, Street and Number 10g. Citizen of What Country? 12612 Molesworth Drive Funera 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. White Specify. Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Minister Religion Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ William Gordon Neese Edith Boyd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, permit. Page 1 and 2 sh Department of Heatth ar Important: If item 27 is any injury or other trau 12612 Molesworth Drive, Mt. Airy, MD John Ashby/Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State Stauffer Crematory 3/18/2012 4 ☐ Donation 5 ☐ Other (Specify) Frederick, MD Stauffer Funeral Home, PA 21. Sign rure of Funeral Service Loensee 22. Name and Address of Facility 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Of set and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Hemorrhanic Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or iinjury holango Corcinama been signed by the attending physician and should be detached for use as the burial-transit that initiated events Due to (or as a consequence of resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause 23e. Did tobacco use contribute to the cause of death? Completed by bheumoutis Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an After this certificate has performed? Yes 2 No 1 Yes 2 No Physician: Be (25. Was case referred to medical examiner? of Vital 26. Place of Death (Check only one) 2 XNO Hospital Other: 욘 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify 27. Manner of Death Date of injury (Month, Day, Year) 28c. Injury at work? Certificate: 28b. Time of 28d. Describe how injury occurred the Hospital or Attending injury 1 Natural 5 Pending 2 Accident Division 1 Yes 2 No Investigation the within 24 hours after deat To the Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number D7297 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

400 W. Marius 400 W. Seventh Street, Frederick, Maryland 21701 31. Date filed (Month 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MARCH Eleanor Dashiell Asplen 00309M Medical Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death County of Death General Cambrisla If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 🗆 M 2 🕱 F Feb. 4, 1910 Maryland **Director** 220-66-4778 102 Yrs. Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f shov event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Dorchester Cambridge 1 🛣 Yes 2 🗌 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1307 Race Street 21613 USA 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 X No If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: white 3 X Widowed 4 Divorced Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Baltimore, Maryland 2121 Elementary/Seconday (0-12) . Page 1 and 2 should be filed within iment of Health and Mental Hygiene. College (1-4 or 5+) owner/operator farm is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ William F. Dashiell ahor Mary Navy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hubert H. Wright IV p.r. P. O. Box 778, Cambridge, MD 21613 other Important: If item any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Old Trinity Churchyard 3/19/12 Church Creek, MD 22. Name and Address of Facility Thomas Funeral Home P.A. of Funeral Service Licensee 700 Locust St., Cambridge, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ pivator disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine been signed by the attending physician and should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? 1 ☐ Yes 2 ☐ No Dav Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 ? autopsy performed? 2 ANO Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 10 Other: 1 Tes ဂ္ 1 Donpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No after death Director: Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 124 hours a Medical 1 gertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Murria Prantil ner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) .15-2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CAMBRIDGE 503 BYRN ST

State Registrar 31. Date filed (Month, Day, Year)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deat Physician/ Steven V. Anderson 2012 March 1518 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arunde1 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days Hours 216-68-9953 1**X** M 2 □ F **Director** 56 Yrs. Mar 10 1955 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location with the Maryland at 10d. Inside City Limits Director r 28a-f sh notified a Maryland Anne Arundel 1 ☐ Yes 2X No Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be r Funeral 187 Brownswood Rd. 21409 USA items ; filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? "natural", or i Black, White, etc. 1X Never Married 2 ☐ Married þ Maryland 21215-0036 1 Yes 2X No Specify: Specify: Completed 3 Divorced 4 Divorced /\$75°75°7/28/75 Black the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12th 0 Housekeeping State of Maryland permit. Page 1 and 2 should be filed v Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 James A. Anderson Sr Evelyn Griffin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James A. Anderson Jr(Brother) 30 D Ironstone Ct. Annapolis, Md. 21403 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Maryland Veteran 3-16-12 Crownsville, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Windame Receise of &cilisons Mortuary, P.A. 1922 Forest Dr. Annapolis, Md. Larr 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart fallure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events southing in death). Let Examiner and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death Unknown the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform after death.

Director: After this certificate Yes To Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes Other: 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending umped 424 vom 12 Accident Investigation 6 Could not be filled in by the 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City on Town, State) determined within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated pur 29d. Date signed (Month, Day, Year)

Registrar

State

x

16

death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Per FH C926 4/25/2012 JH

			For State Registrar	end #J 18	itate of N	Vlarylar		artment of tificate of			-	giene Reg. No. 2	012	10	1.0
	Physicia		Decedent's Name (First Robert	Middle, Last) Leroy Ayre	-c					·	2. Date of Dea	Day	Year	3. Time of	
	Medi Examir		4a. Facility Name (if not ins			·)		4b. City, Town,	or Location	on of Death	March	14, 4c. Coun	2012 ty of Death	6:10	A M
لمب			Frederick Me						Frede				Frede	rick	
L	Funeral Director		5 Social Security Number 514-44-4473 Usual Residence of Dece	6. Sex	- 1	Age (In yrs. I 70	ast birthday) Yrs.	If Under 1 Year Months Day		der 24 Hrs. s Min.	8. Date of Birt (Month, Da July 4,	y, Year)	Coun	olace (State o try) caska	or Foreign
	land f show d at	tor	10a. State 10b.	County		10c. Cit	y, Town or Loc	ation					1	0d. Inside Ci	ity Limits
	e Mary r 28a-	Director	Maryland 10e. Street and Number	Frederic	k ———				ederic	k					2 X No
	with th	erall	6034 Graymont	Drive				10f. Zip Code	217	·04		10g. Citizen of United S		•	ico
036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ed by Funeral	11. Marital Status 1 Never Married 2 3 Widowed 4 D	Married	Was Deceden Armed Forces Yes 2 of Yes, Give Year or Dates.	?	If	/as Decedent of Yes, specify Cu	Hispanic ban, Mexi	Origin? (Spe can, Puerto I	cify Yes or No- Rican, etc.)	14. Ra	ice - Americ ack, White, e	an Indian,	<u> </u>
Baltimore, Maryland 21215-0036	hin 72 houl ne. than "natu e Medical	Completed		Decedent's Educati ly highest grade co (0-12)	mpleted) College (1-4 or	r 5+)	(Give k	ent's Usual Occi ind of work done NOT use retire	e during m d)		ng	16b. Kind of			
d 2	ed witl Hygier other t	Be C	17. Father's Name (First, M.	liddle Last)	5+		Radio	pactive C	1		(Elma National)			ernment	
lan	l be fil fental rked c tic eve	P	Leroy Ayres	idaio, East)					18. 1010		(First, Middle, lie Mae l		ne)		
lary	should and N is ma		19a. Informant's Name/Re		rint)		19b. Mailin	g Address (Stree	t and Nun	nber or Rura	Route Number	; City or Town,	State, Zip C	ode)	
e,	and 2 Health em 27 ther t		Marilyn Ayres 20a. Method of Disposition			20h 5		Fraymont I	rive,	1					
JOT.	age 1 ent of nt: If it y or o		1 Surial 2 Cres	nation 3 🛣 Rem	oval from Stat	te c	emetery, crem	atory or other pl ove Cenete		ĺ	l6, 2012	20c. Location	,		
alti	permit, P Departm Importar any injur once.		21. Signature of Funer a Se	-	0	100		Name and Addi					ck, Nel	oraska	
	Medical Examiner	Examiner	23a. Part 1. Enter the dise shock, or heart failure Immediate Cause (Final disease or condition resulting in death) Sequentially list condition if any, leading to immediat cause. Enter Underlying Cause (Disease or injury	e. List only one cau	Gast: Due to (or as	ne. rointes s a consequ ythnia	tinal Bl						1	Approximate Interval Betwoek Onset and Element Week Hours	ween
Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical Exa	IF FEMALE: 23b. Was decedent pregna in the past 12 months 1 Yes 2 No 9 Unknown	? 1	yes, outcom Live Birth Pregnant Unknown	e of pregnar 2 ☐ Feta at time of d	ncy	Ectopic pregnal Other (specify)	псу				ate of delive	-	⁄ear
S, P.O.	uires that th n signed by uld be detac	þ	Part II. Other significant c					derlying cause o	jiven in Pa	art I.		bacco use con			
al Records,	ian: The law requerificate has bee	Be Completed	Liver and Bo Severe Throm 25. Was case referred to mexaminer?	bocytopeni				26. [Place of D	eath (Check	24a. Was a autop: perfor 1 Yes	sy med?	Were autop prior to con death? 1 Yes	sy findings a apletion of ca 2 No	vailable ause of
Division of Vital	tending Physic leath. or: After this ce the funeral dire	Certificate: To	1 XX Yes 2 No 27. Manner of Death 1 XX Natural 5 1 2 Accident	Pending nvestigation Could not be	al: 1 X Inpa 3a. Date of inj (Month, Da	jury	ER/Outpatient 28b. Time of injury	28c. Inju	ry at	2	ne 5 Reside 8d. Describe ho				
DIVIS	pital or At burs after d eral Direct filled in by		4 Homicide	determined 28	building, e	tc. (Specify)		et, factory, office			8f. Location (St City or Town	n, State)			er,
=	n 24 h	Medical	(Check 2 ☐ Me	tifying Physician: dical Examiner: O tifying Nurse Pra	n the basis of	examination	and/or investig	gation, in my opin	ion, death	occurred at t	he time, date an	d place, and du	e to the caus	se(s) and mar	ner stated
- i	No the within To the complete		29b. Signature and title of c			-		29c. Licens	se number			29d. Date signe	d (Month, D	ay, Year)	
			MA	a					7691			March 1	L4 , 201	2	
	6		30. Name and address of p					^{nt)} reet, Fre	lori al-	Mo1	and 2170	1			
	Stat	e	31. Date filed (Month, Day,	(ear)	32. Registi	rar's Signatu	Ire a		net TCK	, racyl	au ZI/O.	<u> </u>			
	Registra		MAR	16 2012	100	care	D. 100	aked							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 | 1 | 2

			1	For State		State of M	arylan					and M	lental Hy	/gien	е			
				Registrar ecedent's Name	(First, Middle, La	st)		Cer	tificate	of D	eatn		2. Date of De	Reg. N	10. 20	12	1040	{
	Physicia Medic			Kenner	El	izabeth		Ashby	7				March		^{0ay} 2012	Ž ^{ear}	3. Time of Death 5:45 PM	1
	Examir	ner				street and number)			4b. City, To			of Death		4	c. County o			
-	Funeral	7		24 Ben	Dewitt		e (In vrs. la	ast birthday)	Oak If Under 1	lane	d If Under 2	24 Hrs.	8. Date of Bi		Gar			_
	Director		21	3-22-0	794	□ M 2 X F	85	Yrs.		Days	Hours	Min.	(Month, Di	ay, Year)		Count	lace (State or Foreigr ry) fornia	7
	ind show at	ا ة	_	ual Residence of State	Decedent 10b. County		10c. City	y, Town or Loc	ation				0,30,	. , _	<u> </u>		Od. Inside City Limits	_
	Aaryla 8a-f s tiffied	Funeral Director		MD	Howard	ì	Ні	ighlar	nd								1 ☐ Yes 2 🔀 No	
	a or 2 be no	٥	10e.	Street and Num				J	10f. Zip 0	Code				10g. C	Citizen of W	hat Coun		_
	h with	nera	69	02 Bro	oks Roa	ıd			2	077	7				U.S.	Α.		
21215-0036	filed within 72 hours after death with the Maryland tal Hygiene. Id Hygiene. Id other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ρ	1	Marital Status ☐ Never Marrie Midowed 4	ed 2 Married	12. Was Decedent B Armed Forces? 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates.	Ever in U.S No	If	Vas Decede Yes, specif	Cuban,	Mexican,	gin? (Spec , Puerto F	ify Yes or No- lican, etc.)		14. Race Black Specify:	- America , White, e Whi	tc.	
15-(72 hou "nat edica	ple		(Spec	15. Decedent's E ify only highest gr	ducation ade completed)		16a. Deced	ind of work	done dui	ion ring most	of workin	g	16b.	Kind of Bus	iness/Ind	ustry	
12	ed within 7 Hygiene. other than	Completed	El	ementary/Secor	ndary (0-12)	College (1-4 or 5	5+)		NOT use n House	,	Δ				Home			
þ	be filed wental Hyg ked othe	Be	17. F	ather's Name (Fi	irst, Middle, Last)				TOUBC			r's Name	(First, Middle,					_
ylar	should be file n and Mental H is marked o raumatic eve	P	Jo	seph				Smith	ı	L	Fra	nci	s]	Pize	nburgh	
Maryland	2 shou th and 27 is m traum				ne/Relationship (7	* * *		1					Route Numbe					
ē,	and leal leal sm (atny A Method of Dispo		//Daughte							, Oak		ocation - C			_
Baltimore,	permit. Page 1 a Department of H Important: If ite any injury or of			1 ☐ Burial 2 ∑ 4 ☐ Donation	Cremation 3 ☐ Other (Special	Removal from State	Cr	ace of Dispos unitry emato:	s∞ivde ry	er place)		3/9/					le, PA	
Ball	permit Depart Impor any in	Ī		Kich	eral Service Licens	Matthah	An	_ 2		. S	econ	id S	t., o	akl	eral	Hom MD	es P.A. 21550	
П				snock, or neart	failure. List only o	plications that cause on each line	rti death	. Do not enter	the mode of	of dying,	such as c	ardiac or	respiratory ar	rest,			Approximate Interval Between	Ī
,	Ph _{sician} Medical	0 8	disea	ediate Cause (Fi ase or condition Iting in death)		a	De		+ (C	1						14	Onset and Death	
-	Examiner					Due to (or as a	a conseque	ence of):								1		
		iner	Sequent if any	uentially list cond y, leading to imn se. Enter Underly	ditions, nediate	b. Due to (or as a	conseque	ence of):								_	-	_
	cate be executed physician and s the burial-transit	Examiner	that	se (Disease or in initiated events	jury	c. Due to (or as a										-1		_
_	be exe	SalE	resu	lting in death) La	isi	Due to (or as a	conseque	ence ot):										
200	icate l g phys	ledical				d				-								
. Box 68	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as		23b. \ i	MALE: Was decedent p n the past 12 m I Yes 2 I Unknown	enths?	23c. If yes, outcome of Live Birth 1 Pregnant at 9 Unknown	2 Fetal	death 3 🗌	Ectopic pre Other (spec						23d. Date Monti		y Day Year	
Division of Vital Records, P.O.	res that the signed by	d by Pl	Part I			ontributing to death be			derlying cau	use given	in Part I.						cause of death?	
ord	requi	lete		- 1	7)								24a. Was		,		y findings available	_
3ec	he law te has age 2	Completed											autor perfo	osy rmed?	prie dea	or to com ath?	pletion of cause of	
a F	ian: T	BeC		as case referred						26. Place	e of Death	r (Check c	1 L Yes	2 N	0 1	Yes 2	∐ No	
Ž	hysic his ce al dire	욘	1	☐ Yes 2	₩0			R/Outpatient	3 🗆 DOA	Other:	4 🗌 Nur	sing Hom	e 5 Resid	lence 6	6 ☐ Other (Specify)		
n of	ding F h. After t funera	Certificate;	1		5 Pending	28a. Date of injur (Month, Day,	y Year) 2	28b. Time of injury		Injury at work?		- 1	ld. Describe h	ow injur	y occurred			
Siol	Attendr deat	ıţį	3	☐ Accident ☐ Suicide ☐ Homicide	Investigation 6 Could not be		rv - At hom	ne. farm. stree	M et. factory. o		s 2 🗆 N		Rf Location (9	treet an	id Number	or Rural F	oute Number	_
Σ	al Dire	ဦ	4	□ Homicide	determined	building, etc.		, , , , , , , , , , , , , , , , , , , ,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				City or Tow			or muneum	oute Number,	
	e Hospit 24 hour e Funera	Medical		(Check 2 L		sician: To the best of r ner: On the basis of ex se Practitioner: To the	amination a	and/or investic	ation, in my	oninion.	death occi	urred at th	ie time, date a	nd place	 and due to 	the caus	e(s) and manner state	ed.
	To the Complete Compl			Signature and title						cense nu					te signed (/			_
)	160	8/1					397	9			38	6/2	-		
	de	(0				ompleted cause of de												
	Stat	•		Robert ate filed (Month,	A. Gor	alski MD 32. Registrar	r's Signatui	1 N.		th S	5t.,	Oal	<pre>cland_</pre>	MI	215	50		_
	Registra	r		ate filed (Month,	-9 2012	Senta	1.	back	1									

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1017 Physician/ Percy 2:00 PM Hrms trong Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 40 Baltimore University Social Security Number 6 Sex Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Funeral Hours 098-38-2689 **Director** 1 X M 2 ☐ F 60 02/09/1952 NY Usual Residence of Dece or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at by Funeral Director MD Carroll Westminster 1 Yes 2 X No with the Mar 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a (21157 928 Western Chapel Road USA "natural", or items permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No 19
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2X Married 1971 Baltimore, Maryland 21215-0036 1 Yes 2X No Specify. White 3 Widowed 4 Divorced 1975 Completed Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 systems analyst Dept. of Defense Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Charles Armstrong Jean Hoxie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rose Conrad Armstrong/wife 928 Western Chapel Road, Westminster, MD injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) **Carroll** Cremation, Ind. 03/23/2012 Hampstead, MD once, Signature of Funeral Service Licenses 22. Name and APrittsilltFuneral Home and Chapel, P.A. any 412 Washington Road, Westminster, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Hemorr hagie disease or condition Medical resulting in death) Examiner Failure Liver Sequentially list conditions, Examine If any, leading to in medicause. Enter Underlying Due to (or as a consequence oi) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events burial-trar Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the IE EEMALE ase 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No for 5 Other (specify) Pregnant at time of death ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cate has been sig 2 🗹 No 3 Probably 4 Unknown 1 Yes 24a. Was an 24b. Were autopsy findings available autopsy performed? Yes 2 prior to completion of cause of death?

1 Yes 2 No certificate 25. Was case referred to medical examiner?
1 ☑ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital Other: ပု 1 M Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 27. Man r of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No M Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 06-2011

State

101100

21

2012

MD

12 32. Registra Signa

South

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Clark

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 2012 11:15 p.M March 15, Anne E. Brown Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Glade Valley Center Walkersville Frederick 8. Date of Birth If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Jan 20, Year) Hours New York 77 **Director** 045-32-8887 1 M 2 X F Usual Residence of Deceder 28a-f show ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Ijamsville Maryland Frederick 1 ☐ Yes 2 X No 10f. Zip Code 21754 10e, Street and Number 10g. Citizen of What Country? USA Funeral 10231 Royal Saint Andrews Place 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2XXNo 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married by Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: white If Yes Give 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Registered Nurse Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fis marked o Sarah Brown James W. Brown, Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21754 19a. Informant's Name/Relationship (Type, Print) Jane Barger - sister 10231 Royal Saint Andrew Place, Ijamsville, Maryland 1 and 2 s of Health item 27 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 and Department of Hamportant: If ite any injury or ot ☐ Burial 2 Cremation 3 ☐ Removal from State Stauffer Crematory 3-19-2012 Frederick, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland 23a. Part 1 Phter he disease of complications that a shock, or heart failure. List only one gause on each the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate nterval Between Heart Prilive Immediate Cause (Final disease or condition resulting in death) No W TH Physician/ Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or injury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical pe Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 Yes 2 No Month Day Year ate has been signed by the a page 2 should be detached P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1 N 2 🗌 No 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 X No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4X Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred or Attending 1 X Natural 5 Pending s after death. 1 Yes 2 No Accident Investigation filled in by the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital or within 24 hours aff To the Funeral Di completely filled in Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signatur 30. Name and address of berson who completed cause of death (Item 23a) Type, Print) LAYERA BOLANUM (176 T) MVE, SOLTE # 135

DHMH 17 Rev 06-2011

0

Registrar

State

32. Registrar's Signature

ASSAM.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

lliam Magrath	1	1- For State Registrar	tate of Maryla		artment of rtificate of		n and	Menta	al Hyg		leg. No. 2 (0 2 0	4
Physici edical Exami		1. Decedent's Name (First, Midd William	Bigelow		Magr	ath				Date of Dea Month March 11		3. Time of Death 1636 hrs	i
		4a. Facility Name (if not institution		mber)		b. City, To		ocation of		incroit 11	4c. County of	f Death	
Funeral		Memorial Hospital 5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	Easton If Under		If Under:	24Hrs.	8. Date of Bi	Talbot	Birthplace (State or	
Director		041-14-0987	1 <mark>X</mark> M 2∏F	90	Yrs	Months	Days	Hours	Min.		- 1922	Foreign Country) CT.	
any		Usual Residence of Decedent 10a. State 10b. County		10c, City	, Town or Locati	on						10d, Inside City I	Limits
	5	Md. T	Calbot			East	on					1 X Yes 2	
ne Maryland or 28a-f show fled at once.	Director	10e. Street and Number	\!	<u> </u>		10f. Zip C		0.1		1	log. Citizen of Wh	•	
death with the Maryland or items 23s or 28s-f sho must be notified at once.		545 Cynwood I		edent Ever in U	.S. 13. Wa	s Decedent	216		1? (Spec	ify Yes or No	U.S.	A. - American Indian, Black,	
or item	Funeral	1 Never Married 2 M	1 Yes	2 No	If Ye	es, specify (Cuban, I	Mexican, P			White		
urs after tural",		3 X Widowed 4 Div	vorced if Yes, Give Yaa or Dates: ecify only highest grad		5 1 1 1 16a. Decedent	Yes 2X			nd of wor	k done	Specify: 16b. Kind of Bus		
16 n 72 ho nan "na ical Ex	olete	Elementary/Secondary (0-12)	College (1			ost of working			se retired	1)	200		
d within	Completed by	12 17. Father's Name (First, Middle,	, Last)		Civi	l Eng			Name (F	irst, Middle, I	Manufa Maiden Surname)	cturing	
1215 d be file fental H arked o	Be	Ger		th				Anr		Radzin			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked ofter than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	To	19a. Informant's Name/Relations William B. Mag	1 (2) /	n							nber, City or Towron, $\mathbf{D.C.}$	n, State, Zip Code) 20007	
ore, Is and Stream		20a. Method of Disposition 1 X Burial 2 Cremation	n 3 Removal fro	nm State	Place of Disposi crematory or oth	er place)				Date		City or Town, State	
ti. Page rtment c		4 Donation 5 Other State 21. Signature of Funeral Service	pecify:	Ke	nsico C						Valhall		
Ba Perm Depa Impr		/ /		F.5P	Hu:	rreyn O. Box	E OS k 51	trows 8 St.	ski 1 . Mic	Funera chaels	l Home P , Md. 21	663	
Physician // /Medical		23a. Part I. Enter the disease, or failure. List only one cause	on each line.				dying, su	uch as card	diac or re	espiratory arr	est, shock, or hea	rt Approximate Int Between Onset Death	
≛xaminer		Immediate Cause (Final disease or condition resulting in death)		consequence of		ease						Death	
	Je.	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequence o	rf):								
u.	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a	consequence o	f):		·				···		
o, e be executed ysician and burial - transit	a E	- WIDENDED	d					_					
60, ate be e hysician e burial	Medical	UNPENDED IF FEMALE:	23c. If yes. o	outcome of preg	nancv						23d. Date of o	lelivery	
Box 6876 e death certificate the attending phy ed for use as the b	ä	23b. Was decedent pregnant in the past 12 months?	1 Live b		2 Fet	al death		Ectopic pr	regnancy	1	Month	Day Year	,
Box ie death the atte	Physic		known 9 Unkno	wn	- J ∪th	er (Specify							
cords, P.O. Box 68760, In requires that the death certificate be executed has been signed by the attending physician and should be detached for use as the burial - transi	2	Part II. Other significant conditions Right hip fracture, Dia	2011 000 000		esulting in the ur dementia	nderlying ca	use give	en in Part I	1.			ute to the cause of death	
v requires s been s should t	letec									24a. Was a		ere autopsy findings avail or to completion of cause	
tal Reccition: The lar	Completed											eath? Yes 2 No	
of Vital Records, as Physician: The law require. The the requirement of the control of the contr	o Be	25. Was case referred to medical examiner?	Hospital: 1 🗸 Ir	npatient 2	ER/Outpatient		104	Death (Ch			Residence 6	Other:	
ding Phy	-	1 Yes 2 No 27. Manner of Death 1 Natural 5 Death	28a. Date of (Month)	of Injury	28b. Time of In	jury 28c	. Injury a	at Work?	28		now injury occurred	<u></u>	
the state O	icatic	2 Accident Inves	stigation 28e Place		ome, farm, street			ding etc	°		Street and Number	or Rural Route Number,	City
Division Hospital or Attence 44 hours after death Funeral Director: tely filled in by the	Certification:		d not be	Nursing Ho			noo ban	unig, oto.		or Town, S			Oily
Divis To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	I	(nysician: To the best miner:On the basis o										
To To Com	Medical	29b. Signature and title of certifie	and manner st				icense n					(Month, Day, Year)	
		Mh B	ull M	<u>D</u>		C	.C.M.	E			March 13, 2	012	
YHVA		30. Name and address of person Melissa Brassell, MD	who completed cause Assistant Med			Baltimo	re Stre	et, Balt	imore.	MD 2122	 :3		
St	ato	31. Date filed (Month (A) (P)		istrar's Signatu		1			,				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

uciano Josefino Alarcon-Balmes State of Maryland / Department of Health and Mental Hygiene																
	1- For State Registrar Certificate of Death Reg. No. 20 2 04 Physician 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 3. Time of Death															
Physicia Medical Exami		1. Decedent's Name (First, M Luciano Jose			n Ba	lmes	5				2	2. Date of Dea Month March 26		Year 2		3. Time of Death 2228 hrs
		4a. Facility Name (if not instit	ution, give	e street and nun				1 . 1		Location o	f Death		40	c. County of		
Funeral		Doctors Community 5. Social Security Number	6. Se		7. Age (In	vrs, las	t birthday)		ham nder 1 Yea	r If Unde	r 24Hrs.	8. Date of Bi		Prince G		nplace (State or
Director		216-21-4021		M 2 F	54	,		Mon				10/23			Foreign	
b	ļ	Usual Residence of Deceder			Itos	City T		ntine.				<u> </u>				10d. Inside City Limits
d Sow any							own or Loc									1 Yes 2 No
larylan 28a-f sl	Director	Maryland Prin 10e. Street and Number	ce G	eorges		New	Carro		ip Code			1	10g. Cit	izen of Wha	at Coun	try?
215-0036 • be filed within 72 hours after death with the Maryland ntal Hygiene. rked other than "natural", or items 23a or 28a-f showent, the Medical Examiner must be notified at once.		7905 Legatio	n Ro	ad					0784					Mexic		
ath with	Funeral	11. Marital Status 1 Never Married 2 X	Married	12. Was Dece Armed For	rces?					spanic Orig n, Mexican,		cify Yes or No tican, etc.)	D-	14. Race - White,		an Indian, Black,
[등 등	by Fu		•	1 Yes If Yes, Give Year or Dates:	2 X	No	1 5	Yes	2 No	specify:	Mex:	ican		Specify: T	√hi+	e
hours a		15. Decedent's Education (S		nly highest grade		ed) 1				tion (Give k				Kind of Bus	iness/Ir	
136 hin 72 c. than "	Completed	Elementary/Secondary (0-	12)	College (1-	4 or 5+)		Cons	struc	tion					aul Ro		on, C,.
21215-0036 auld be filed within 77 Mental Hygiene. marked other than e event, the Medical	5	17. Father's Name (First, Mid		-			COIL	oci uc		18.Mother:	s Name (First, Middle,			ICLI	OII, C,.
동교육들리	BB	Antonio Ala 19a. Informant's Name/Relati		una Brint \			10h Mail	lina Addra	Chan			Balmes Iral Route Nur	C	Situate Taxas	Chaha	Zio Codo)
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. Lant: If item 27 is marked other than "natural", or other traumatte event, the Medical Examiner.	-1	Reyna Alarcon		• • • •			İ	•	•			Carro	,	•		, ,
re, range of treat	Ī	20a. Method of Disposition 1 X Burial 2 Crema	tion 3	Pernoval fro		20b. Pla	ace of Disc	osition (N	ame of ce	metery.		Date	20c.	Location - 0	City or	Town, State
Baltimore, pernit. Pages I at Department of the Important: If the		4 Donation 5 Other	Specify:		III Otato	Gua						3/2012				
Baltimore, MD 2 permit. Pages I and 2 shoul Department of Health and M Important: If Item 27 is m injury or other traumatie		21. Signatur of Funeral Serv	ice Licen:	see Ron	nd)	_				of Facility	1001	ndon/Ha Lanhan				Hame
Physician		23a. Part I. Enter the disease failure. List only one car	, or comp	lications that car		death. D	o not ente	r the mode	e of dying,	such as ca	ardiac or i	respiratory an	rest, she	ock, or hear	t 00	Approximate Interval Between Onset and
Medical Examiner	1	Immediate Cause (Final dise	ase a.	Cardiac	Arr	hytl	hmia									Death
		or condition resulting in death Sequentially list conditions,		Due to (or as a d												
	je.	if any, leading to immediate cause. Enter Underlying Cau	ifie	Due to (or as a												
p sit	Examiner	(Disease or injury that initiate events resulting in death) La		Due to (or as a	conseque	nce of):										
		■ UNPENDED	d	AMENDED #	1 as	not	ted, 2	3a-b,	.27,p	er me	, g92	8 6-22	-12	sm		
'60, sate be on the buria		IF FEMALE:		23c. If yes, or										d. Date of d	lelivery	
Box 68760, e death certificate both attending physical for use as the bu	Sian/	23b. Was decedent pregnant i past 12 months?	n the	1 Live bir	th nt at time	of deatl	, - H	Fetal deat Other (Sp		Ectopic	pregnan	СУ		Month	D	ay Year
Box e death the atte	Physic	1 Yes 2 No 9	Unknown	9 Unknov	₩n			Other (O	Jechy)							
P. P. S. that s. that	5	Part II. Other significant cor	iditions	contributing to	death but	not resi	ulting in the	e underlyii	ng cause g	given in Par	t I.			use contrib	_	he cause of death? ably 4 Unknown
rds, require been sig	Completed	-										24a. Was				opsy findings available
ecol he law ate has	dwo											autor perfo 1 V Yes	med?	de	ath?	
tal Rec	Be C	25. Was case referred to med examiner?	100	leasibely man					_	of Death (
Division of Vital Records, tal or Attending Physician: The law requir rs after death. al Director: After this certificate has been so led in by the funeral director; page 2 should law to the thing the funeral director.	.0	1 Yes 2 No 27. Manner of Death					R/Outpatie			ry at Work?		Home 5			Other:	
sion of trending Pt death. ctor: After in y the funeral	ţį	1 X Natural 5 P	ending	28a. Date o (Month, I	Day,Year)			,,		res 2				,		
Division pital or Attent ours after death neral Director:	Certification	3 Suicide 6 0	nvestigatio Could not b	be 28e. Place	of Injury	- At hom	ne, farm, st	reet, facto	ry, office b	uilding, etc	. 2	8f. Location (and Number	or Rur	al Route Number, City
Ospital hours a neral y filled		4 Homicide	etermined	(
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director:	Medical	(Check only		an: To the best On the basis of and manner sta	examina											
2.2 E 8	¥	29b. Signature and title of cer	tifier	and mariner sta	ated.			2	9c. Licens							th, Day, Year)
The state of the s		0-0-	-						O.C.I	M.E.			Mar	rch 29, 20	012	
44		 Name and address of per Donna M. Vincenti, 		completed cause Assistant M		•		0 W. Ba	altimore	Street, I	Baltimo	ore, MD 21	223			
		31. Date filed (Month, Day, Ye	ar)	32. Re	istrar's	opatye										-
Regist	rar	MAN O UWIL	MARIE	1												

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 0215A M March 201 Medical Facility Name (if not institution, give street and number) Examiner or Location of Death 4c. County of Death MUTC 8. Date of Birth (Month, Day, last birthday If Unde 9. Birthplace (State or Foreign **Funeral** 219-36-5125 **Director** 1 🗆 M 2 🛣 Apr. 5, Maryland 73 1938 Usual Residence of Decedent or 28a-f show notified at within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Dorchester Hurlock MD 1 X Yes 2 No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? 2 should be filed within 72 hours after death with the th and Mental Hygiene.
27 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be a Funeral 45 Delaware Avenue Apt. 21643 United States 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Maryland 21215-0036 1 ☐ Yes 2X No Specify. Black Completed 3 Widowed 4 Divorced Specify 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Food Processing Food Processor 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) e 1 and 2 should be fi of Health and Mental ပ Rome Butler Lula Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. PO Box 2433, Paltsergh, NY 12901 Robin M. Caudell/Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 03/24/12 | Preston, Maryland Pleasant Cem. Mt. 4 Donation 5 Other (Specify) 22. Name and Address of Facility Framptom Funeral Home, P.A. Signature of Funeral Service Licenses 216 N. Main St., Federalsburg, MD 21632 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Respirator 4 Failure disease or condition 12 hows Medical resulting in death) Due to (or as a consequence of Examiner Encephalitis 4 weeks Sequentially list conditions Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that the death certificate be executed and burial-tra that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Day 4 ☐ Pregnant at time of death 9 ☐ Unknown signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by or Attending Physician: The law requires 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown should . Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy perforn death? certificate 1 Yes 2 No 2 X N Yes 25. Was case referred to medica Certificate: To Be 26. Place of Death (Check only one) 2 X No Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 24 hours after death. Funeral Director: A 1 Yes 2 No ☐ Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completely (Check within 24 3 [Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) RES-000 March 20th, 2012 enne aure 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Monica

31. Date filed (Month, Day

emmon

N.

(200

Bull more MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 1708 M Virginia Lee Bradley March 19 2012 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Easton Talbot Memorial Hospita If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) October 12, 1933 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 ☐ M 2 🔀 F Maryland Director 220-32-7536 78 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 28a-f shov 1 XYes 2 □ No Directo Maryland Caroline Denton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 328 Carter Avenue 21629 Funeral USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Marylahd 21215-0036 1 □Yes 2 No If Yes, Give Year or Dates: \$ Specify Specify: 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 H.S. Grad. Bookkeeper Banking 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ည Frank Lituski E11a Knox 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Ernest Bradley, Jr./son 25335 Calvert Drive Greensboro, Maryland 21639 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 3/26/2012 Greensboro, Maryland Holy Cross Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Moore Funeral Home, P.A. 1/1ocm aux 12 South 2nd Street Denton, Maryland 21629 Part 1. Enter the disea e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Immediate Cause (Final disease or condition resulting in death) **Physician** ACUTE PULMONARY EMBOLISM MINUTES /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) 1 □Yes 2 ☑ Mo the 9 Unknown ģ signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 2 N 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending 1 ☐Yes 2 ☐ No investigation 2 Accident 24 hours after deat Funeral Director; 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🕒 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

within 2

Virginia

Bradley

State Registrar

29b. Signature and title of certifier

ROLLI

kamen

31. Date filed (Month, Day, Year) 32. Registrar's Signature MAR 2 1 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAMESH

MD

2195

DHMH 17 Rev 1/2001

29c. License number

WASHINGTON ST,

DO066441

EASTON

29d. Date signed (Month, Day, Year)

MD

MARCH 19 2012

21601

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 8:25 AM George Paul Brown 08 2012 March Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 6410 Redcrest Avenue Seaford Dorchester If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea June 11 Social Security Number . Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Hours Year 203-44-5191 Pennsylvania Director 58 Usual Residence of Decedent 10a. State 10c. City, Town or Location at the Maryland Director 3a or 28a-f sh t be notified a Seaford Dorchester MD 1 Yes 2x No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a and my injury or other traumatic event, the Medical Examiner must be once. Funeral 19973 6410 Redcrest Avenue United States 12. Was Decedent Ever in U.S. Armed Forces? 1 Xyes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Completed by 1 Never Married 2X Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates. 25 Yrs 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Solo Cup Mechanic 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alyce Brown/Spouse 6410 Redcrest Avenue, Seaford, DE 19973 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State ☐ Burial 2 😾 Cremation 3 ☐ Removal from State 03/16/12 Federalsburg, Concord Cemetery 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Service Licensee 22. Name and Address of Facility Framptom Funeral Home, P.A. CFSP Main St., Federalsburg, MD 21632 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician. disease or condition resulting in death) Carda Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Exami End and that initiated events resulting in death) Last Due to (or as a consequence of) use as the burialphysician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No for Month Pregnant at time of death 9 Unknown the a 1 Yes 2 L ed by t signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown DIFTERFE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2: autopsy performed 2 No 1 Yes Yes director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA After this 24 hours after death.
Funeral Director: After this eted filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending work?
1 Yes 2 No 1 Natural Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier within 24 hor To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

D. U.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Drive Federalsburg

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29d. Date signed (Month, Day, Year) March 8th

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** March 3, 2012 РМ 1:20 Alberta Ann Blades /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Caroline Envoy of Denton Denton If Under 1 Year Months Days Social Security Number 6. Sex 7. Age (In vrs. last birthday If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Min. 1 □ M 2 □ VF Hours Director 88 June 29, 1923 Maryland 217-28-4486 should be filed within 72 hours after death with the Maryland and Mental Hygiene. s marked other than "natural", or items 23a or 28a-f show 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Queen Anne Chester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21619 304 Skipper Lane USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give X Year or Dates: 1 Never Married 2 Married 2 No ve X 1 ☐ Yes 2 📉 No Specify Specify: Completed by 3 XWidowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Seamstress/Factory Worker Seamstress/Clothing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be h and Mental Helen Victory ပ Unknown Carr 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Ellen Hutson/daughter-in-law 304 Skipper Lane Chester, Maryland permit. Pages 1 and Department of Healt Important: If Item 2 any injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) 3/7/2012 Denton, Maryland Denton Cemetery 21. Signature of Funeral Service Lig 22. Name and Address of Facility Moore Funeral Home, P.A. box Denton, Maryland 21629 12 South Second Street 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) ears /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or injury that initiated events attending physician and for use as the burial-trai resulting in death) Last Due to (or as a consequence of) by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 T Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 🙀 No 3 Probably 4 ☐Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1∐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury at Work? 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident the Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, or Attending Physician: death. To the Hospital or within 24 hours aft To the Funeral Di

this certificate

Baltimore, Maryland 21215-0036

Pages 1 and 2 s ment of Health an

State Registrar

Medical

Wafik I. Zaki, M.D.

29a. Certifier

(Check only one)

and manner stated.

D004753L

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

836 S. 5th Ave.

Denton, Maryland 21629

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 29, 2012 3:32p February William Belser Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Frederick 531 Heather Ridge Drive Unit A Frederick Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) **Funeral** Hours 218-38-8509 **Director** 1 X M 2 D F 72 May 8, 1939 Pennsylvania Usual Residence of Dec show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director notified 28a-f 1 Yes 2 □ No Frederick Frederick Maryland Maryland 10e. Street and Numbe 10f. Zip Code ò 10g. Citizen of What Country? must be Funeral 21702 531 Heather Ridge Drive Unit A USA items filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. 6 þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify White Specify "natural" 3 X Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me +2 College (1-4 or 5+) Elementary/Secondary (0-12) Computer System Analyst Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Evalyn Swartz Frank N. Belser 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1047 Tomahawk Trail, Unit B, Incline Vill, NV 89451 Suzanne Belser/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐X remation 3 ☐ Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) 3/14/2012 Stauffer Crematory Frederick, Maryland Signature of Funeral Service Lice 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, 21702 (Tr) the Part 1. Enter the disease, or complications shock, or heart failure. List only one cause that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest on each line. Interval Between Immediate Cause Final Onset and Death Ph_sician/ Pars disease or condition Medical resulting in death) **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to for as a consequence of Exami Cause (Disease or injury that initiated events resulting in death) Last the burial-tran Due to (or as a consequence of): attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 for use as IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death detached the g 🗌 Unknown signed by Part II. Other significant conditions contributing to death, but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be 2 No 3 Probably 4 Unknown 1 Yes peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l autopsy performe Yes completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: _2 🗌 No ပ္ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) er of Death Certificate: 1 Natural 28b. Time of 28c. Injury at hin 24 hours after death. the Funeral Director: After 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) within To the 29b. Signature and title of certification 29c. License number

Q)

Registrar

State

32. Re

MAR

strar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Thomas Wayne Butler March 20 2012 12:53pM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 37540 Harrow Hills Court St. Mary's Mechanicsville Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex 7. Age (In yrs. last birthday, **Funeral** 9. Birthplace (State or Foreign Hours 1 XM 2 🗆 212 76 9733 Mar. 8, 1960 Maryland **Director** 52 Usual Residence of Decedent or 28a-f show 10a. State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🖳 No MD St. Mary's Mechanicsville 10e. Street and Number 10g. Citizen of What Country? 27195 Tintop School Road 20659 US 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. þ 1 X Never Married 2 Married Yes Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black Completed 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Electrician Private ,17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Vincent Butler Florence Woodland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20695 37540 Tintop School Rd Mechanicsville, MD Mary M. Wheeler/sister 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Sacred Heart 1 KBurial 2 Cremation 3 Removal from State 3-28-2012 Bushwood, MD 4 Donation 5 Other (Specify) 21. Signat of Funeral Service Lj 22. Name and Address of Facility BRISCOE-TONIC FUNERAL HOME 38576 Brett Way Mechanicsville, MD 20659 23a. Part/1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition

a. Meter the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between 2 Mow THS ∲nysician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, it any reading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit To the Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Year Day Pregnant at time of death Unknown signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy performed Yes 2 prior to completion of cause of death? this certificate 1 Yes 2 No 25. Was case referred to medical æ 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6X Other (Specifysister shore 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending injury 2 Accident
3 Suicide Investigation 1 Yes 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Continue Practice of Lithing and one of my uncoded and occurred at the time, date and place and due to the cause(s) and manner at estated. (Check 29b. Signature and Name and addre s of person who completed cause of death (Item 23a) (Type, Print) HOSTITAL, 25500 POINT LOUKOUT ROAD, LEWARDTOWN, MD-20650 MIR ST. MARY'S

DHMH 17 Rev 7/2009

State Registrar

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		_ For	Please	State of							all Copies Iental Hyg			101.	1.0
	•	State Registrar					tificate					Reg. No.	. U I Z		
Physicia Medic		1. Decedent's Name Nancy V	e (First, Middle, La Wallace	,							2. Date of Dea Month 03	Day	Year 2012	3. Time of Death	
Examin		4a. Facility Name (if			,		4b. City,						nty of Death		
Funeral		Feninsul 5. Social Security N	umber 6.5		. Age (In yrs. I	enter (last birthday)	If Under		If Under		8. Date of Birt	h	9. Birth	place (State or Forei	ian
Director		422-58-6		□ M 2 🔀 F	71	Yrs.	Months	Days	Hours	Min.	(Month, Day $4/1/1$		Cour	KY	3,,
ind show at	٥٠	Usual Residence of 10a. State	10b. County		10c. Cit	ty, Town or Lo	cation				1/ 1/ 1	3 10		10d. Inside City Limi	its
Maryla 28a-f e	Director	MD	Worce	ster		Berli	n							1 🗌 Yes 2 🕱	No
2 hours after death with the Maryland "natural", or items 23a or 28a-f show idical Examiner must be notified at	ral D	10e. Street and Nun					10f. Zip					10g. Citizen		ntry?	
ems 2	Funeral	20 / Hei	nry's M	111 Dr.	ent Ever in U.	S. 13. V		218] ent of His		igin? (Spe	cify Yes or No-		SA tace - Americ	can Indian	
ifter de ", or it amine	by		ied 2 Married	Armed Force 1 Yes 2 If Yes, Give			f Yes, spec				Rican, etc.)	Е	llack, White,	etc.	
atural	eted	3 Widowed	4 L Divorced	Year or Date	es.	16a. Deced						Spec	VV 1.	ite	
in 72 t e. han "n Medi	Completed	(Spe	ondary (0-12)	rade completed) College (1-4	or 5+)	(Give	kind of wor O NOT use	k done di		it of worki	ng	TOD. KING O	Business/Ir	dustry	
ed with Hygien Ither th	Be C	17. Father's Name (i	First Middle Last)	4		Art	ist		40.55.41			Ar			
be file lental l rked o ic eve	To	,	Wallace								e (First, Middle, Nelson		ıme)		
should and N is ma auma		19a. Informant's Na		Type, Print)		19b. Mailir	ng Address	(Street a			I Route Number		, State, Zip	Code)	
and 2 Health em 27 ther tr		Conrad 20a. Method of Disp	Bergo ,	/ husba					Mil		c., Be				
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Be a showloarth: If them 27 is marked other than "natural", or items 23a or 28a-1 showland injury or other traumatic event, the Medical Examiner must be notified at once.		1 Burial 2	Cremation 3		tate C	Place of Dispo cemetery, cren	natory or o	ther place) 9/2012		on - City or To		
rmit. P spartm portar y injur		21. Signature of Fur	neral dervice Licen	see							bage				
a La Co						1	08 W	i11i	iam	St.	Ber1	in, M			
Physician/ Medical		23a. Part 1. Enter t shock, or hear Immediate Cause (disease or condition resulting in death)	Fina!	a. Valv	as a consequence	He	er the mode			cardiac o		est,		Approximate Interval Between Onset and Death	
Examiner	iner	Sequentially list co if any, leading to im cause. Enter Under	nmediate rlving	b. Due to (or	as a consequ	uence of):									
be executed sician and burial-transit	cal Examiner	Cause (Disease or that initiated events resulting in death) I	S	c. Due to (or	as a consequ	uence of):									
icate b physics the t	ledic			d											
To the Hospital or Attending Physician: The law requires that the death certificate is within 24 hours after death. within 24 hours after death. completely filled in by the funeral director, page 2 should be detached for use as the longletely filled in by the funeral director, page 2 should be detached for use as the longletely filled in by the funeral director, page 2 should be detached for use as the longletely filled in by the funeral director, page 2 should be detached for use as the longletely filled in by the funeral director, page 2 should be detached for use as the longletely filled in by the funeral director, bage 2 should be detached for use as the longletely filled in by the funeral director.	Physician/Medio	IF FEMALE: 23b. Was decedent in the past 12 r 1 Yes 2 9 Unknown	months?		rth 2 🗌 Feta int at time of c	aldeath 3	Ectopic p Other (sp		′				Date of deliv Month	ery Day Year	
uires that the signed by the signed by the details and the details.	by	Part II. Other signif	icant conditions of	ontributing to dea	th but not res	sulting in the u	inderlying c	ause give	en in Part	I.	23e. Did to	_ /		he cause of death?	wn
The law req ate has bee page 2 sho	Completed										24a. Was a autop perfor		b. Were auto prior to co death? 1 \(\sum \) Yes	psy findings availab empletion of cause o	ole of
ician: certifica rector,	Be	25. Was case referre examiner?	ſ	Hospital:						ith (Check					
y Phys er this (eral dii	e: To	27. Manner of Death	h No	1 🗹 In	injury	ER/Outpatier 28b. Time of		Other Bc. Injury	4 L N		me 5 🗌 Resid			2	
ending eath. or: Afte the fun	Certificate:	1 Natural 2 Accident 3 Suicide	5 ☐ Pending Investigatio 6 ☐ Could not b	n	Day, Year)	injury	М	work?			-04. 5 0001100 11	ow injury occ			
ital or Att urs after d ral Direct lled in by		4 🗌 Homicide	determined	28e. Place o building	, etc. (Specify						City or Tow	n, State)		l Route Number,	
the Hosp hin 24 hor the Fune upletely fi	Medical	(Check 2 only one) 3	Certifying Nur	i iner : On the basis	of examination	n and/or invest	tigation, in n	ny opinior	n, death o	ccurred at	the time, date a	nd place, and	due to the ca	use(s) and manner st	tated.
5 w ₹		29b. Signature and	halas	L Oglo	un_	- ho	29c	D34	59	3		3 / 1	ned (Month,	Day, Year)	
15		30. Name and address	1 L. 091	burn .	of death (Item	23a) (Type, F	Print)	Stre	et.	Sul:	sbury 1	Maryla	ind o	21801	
Stat Registra		31. Date filed (Monti	MAR 19		istrar's Signa	ture A	back	7							

DHMH 17 Rev 06-2011

Ling Li, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 32. Registrar's Signature State Registrar

30. Name and address of person who completed cause of death (Item 23a)

ack

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

nyllis Butz	1- For State	Certificate of	f Health and Mental f Death		g. No. 20	2 1042
Physician				2. Date of Death Month	h Day Year	3. Time of Death 1645 hrs
ledical Examine	PRIVILIS BUCZ 4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Dea	March 24,	2012 4c. County of Deat	
1	Johns Hopkins Bayview Medical Center		Baltimore			
Funeral Director	218-26-3461 _{1 M 2 XF}	(In yrs. last birthday) 81 Yrs		8. Date of Birt 10/26	Forei	rthplace (State or gn Maryland buntry)
kus		10c. City, Town or Locat				10d. Inside City Limits
E	MD Baltimore	Baltimor	e			1 Yes 2 No
the Maryland a or 28a-f sh tified at once	10e. Street and Number 706 49th Street		10f. Zip Code 21 224	10	g. Citizen of What Cou USA	ntry?
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygie with "natural", or items 23a or 28a-f she Important. If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director		X No	as Decedent of Hispanic Origin? (/es, specify Cuban, Mexican, Pue		White, etc.	rican Indian, Black, Thite
urs after hural", miner	3 X Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade comp	pleted) 16a. Deceder	Yes 2 X No specify: nt's Usual Occupation (Give kind o	of work done	Specify: Vi 16b, Kind of Business/	
5-0036 ed within 72 hour hygiene. to ther than "natt the Medical Exart Completed	Elementary/Secondary (0-12) College (1-4 or 5-	+) during m	nost of working life. DO NOT use r Omemaker		Home	,
filed will Hygie at other		•		me (First, Middle, M	laiden Surname) n Breeden	
2121 ould be fi ould be fi s marked iie event,		19b. Mailing	g Address (Street and Number of			e, Zip Code)
MD and 2 shr and 27 in armstraumst	Valerie Peeler/ Daughter 20a Method of Disposition		49th Street Bal	timore, N	4D 21224 20c. Location - City or	Town State
imore, Pages l a nent of He ant: If ite	1 Burial 2 X Cremation 3 Removal from Stat 4 Donation 5 Other Specify:	crematory or otl	her place) ematory, INC.	rch 27, 2012	Baltimore	·
Balti permit. Departi Import injury	21. Signature of Funeral Service Licensee	CR	Name and Address of Facility EMATION DIRECT 5 Ritchie Hwy.	Seve	rna Park, M	ID 21146
Physician /Medical ixaminer	23a. Part Enter the disease, or complications that caused to failure. List only one cause on each line.		he mode of dying, such as cardiac Atherosclerotic (Approximate Interval Between Onset and Death
Xammer	or condition resulting in death) Due to (or es a consec					
ted Junsit Examiner	Sequentially list conditions, If any, landing to immediate cause. Enter Underlying Cause (Disease or injury that initiated					
ecuted and transit	events resulting in death) Last Due to (or as a consec	quence of):				
60, te be execu ysician and burial - tra	✓ UNPENDED ☐ AMENDED 23a,		g928 6-1-12 sm			
ox 6876 ath certificat attending phy for use as the		2 Fe	otal death 3 Ectopic preg	nancy	23d. Date of deliver Month	y Day Year
C # 25 0		but not resulting in the ι	underlying cause given in Part I.		pacco use contribute to	
- s .50 e -				1 Yes	2 No 3 Prol	bably 4 Unknown utopsy findings available
Division of Vital Records, to a Attending Physician: The law requires and redeath all Director: After this certificate has been signed in by the funeral director, page 2 should be artification: To Be Completed				autops perform	med? prior to death?	completion of cause of
ital Redicion: The scertificate irector, page	25. Was case referred to medical examiner? Hospital:	nt 2 ER/Outpatient	26.Place of Death (Chec		Residence 6 Othe	-
on of Vinding Physich. r: After this te funeral different To	1 Yes 2 No 27. Manner of Death 1 X Natural 5 Pending 1 Pending				ow injury occurred	
Division o To the Hospital or Attending within 24 hours after death To the Funeral Director: After completely filled in by the fune ledical Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)	ıry - At home, farm, stree	et, factory, office building, etc.	28f. Location (S or Town, St		ural Route Number, City
To the Hospital within 24 hours To the Funeral completely filled	29a. Certifier 1 Certifying Physician: To the best of my one) 2 Medical Examiner: On the basis of exam and manner stated.		·			
	29b. Signature and title of certifier		29c. License number O.C.M.E.		29d. Date signed (Mo	nth, Day, Year)
	30. Name and address of person who completed cause of de Ana Rubio MD. Assistant Medical Exami		imore Street Baltimore	MD 21223		
State	31. Date filed (Month, Day, Year) 32. Registrar	s Signature				
Registra	MAR 27 2012 / Burn	was to the	ACCOUNT OF THE PERSON OF THE P			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ OBERT BUCCINO COAM Medical 4a. Facility Name (if not institution, give street 4b. City, Town, or Location of Death Randallstown Examiner 4c. County of Death Northwest Hospital Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) Days Hours 127-20-8618 Director 82 1 XXM 2 - F Vrs 8/24/1929 New Jersey show 10c. City, Town or Location 10d. Inside City Limits Director 28a-f notified Maryland Prince George's Bowie 1XXX Xos 2 I No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? pe ral", or items 23a e Funeral 12302 Madeley Lane 20715 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. Completed by 1 Never Married 2XXMarried 1 ☐ Yes XX No Specify. White Specify "natural" 3 Widowed 4 Divorced Year or Dates. 51-53 the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) ed other than " Elementary/Secondary (0-12) College (1-4 or 5+) Mental Hygiene. Sales Manager Sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Thomas Anthony Buccino Angeline Kelly of Health and Nitem 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12302 Madeley Lane, Bowie, Md. 20715 Joan V. Buccino 20a. Method of Disposition
1 □ Burial 2 XX cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date o ± o Department of Important: If any injury or Huntt Crematory 3/15/2012 Waldorf, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Robert E. Evans Funeral Home 22. Name and Address of Facility 16000 Annapolis Road, Bowie, Md. 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final rom Bosis Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Oncertying Cause (Disease or injury Due to (or as a consequence of): and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical as the IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy
☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No jo Year Month Pregnant at time of death Dav signed by the a g Unknown 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ been sig Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy perform this certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred

The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 or Attending Physician: To the Hospital or Attending F within 24 hours after death.
To the Funeral Director: After it

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

filled in by

6-1 State

Medical

Natural Accider

3 Suicide

29a. Certifier

(Check only one

Accident

29b. Signature and title of certifier

5 Pending

Investigation 6 Could not be

work?
1 Yes 2 No

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or inventigation is a stated of the cause of examination and/or inventigation is a stated of the cause of examination and or inventigation is a stated of the cause of examination and or inventigation is a stated of the cause of examination and or inventigation is a stated or inventigation and or inventigation and or inventigation is a stated or inventigation and or inventigation is a stated or inventigation and or inventigation is a stated or inventigation and or inventigation is a stated or inventigation an

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 14, 2012 Year Marion Irene Bowser 7:15 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Goodwill Mennonite Home Grantsville Garrett 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Jűîy, 20, 1916 Maryland 95 Yrs **Director** 216-14-1129 Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location be notified at 10d. Inside City Limits Direct MD Garrett Grantsville 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral within 72 hours after death with ral", or items 23a Examiner must b 1547 Chestnut Ridge Rd. 21536 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Bace - American Indian or i Armed Forces Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural", Specify: Completed 3 XWidowed 4 Divorced White Year or Dates th and Mental Hygiene.
27 is marked other than "natur traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) School Teacher Public Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be file if Health and Mental H item 27 is marked of ပ Thomas Hannon Versa Dailey and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fred E. Bowser, Jr./Son 5112 Amish Rd., Grantsville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1
Department of
Important: If it
any injury or o Grantsville Cemetery March 17, 2012 Grantsville, MD 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of Facility Newman Funeral Homes, P.A. 21. Signature of Funeral Service Licenses - of P.O. Box 275, Grantsville, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or reart failure. List only one cause Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Priysician neumonia Medical Examiner Sequentially list conditions if any, leading to immedicause. Enter Underlying Exam Cause (Disease or linjury that initiated events resulting in death) Last and burial-tra Due to (or as a consequence of) attending physician Physician/Medical requires that the death certificate be Box 68760 as the l IF FEMALE use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Year Pregnant at time of death g 🗌 Unknown Division of Vital Records, P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? δ 2 No 1 Yes 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an To the Hospital or Attending Physician: The law r within 24 hours after death.

To the Funeral Director: After this certificate has b page 2 s autopsy performed death? 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No 1 Yes Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation filled in by the 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) March 14, 2012

Registrar

State

31. Date filed (Month, Day, Year) **MAR 16 2012**

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robin Bissell, 124 Miller St., Grantsville, MD

21536

1	2-	02	14	46	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	Year 3. Time of Death 0610 hrs
4a. Facility Name (if not institution, give street and number) Montgomery General Hospital 4b. City, Town, or Location of Death Montgomery General Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Montgomery Hours Mingle Days Hours Mingle Montgomery	0610 hrs
Montgomery General Hospital Olney Montgomery General Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Montgomery Hours Min. Montgomery General Hospital 6. Sex 7. Age (In yrs. last birthday) Montgomery General Hospital Montgomery General Hospital Montgomery General Hospital Montgomery General Hospital 7. Age (In yrs. last birthday)	
Funeral 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/)	ounty of Death
Months Dave House Min	ntgomery
$\frac{1}{220-02-0043}$ $\frac{1}{100}$ YYYY) 9. Birthplace (State or Foreign Maryland	
	Country)
Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
	1 Yes 2 No
Maryland Montgomery Poolesville 106. Street and Number 106. Zip Code 109. Citizen of	of What Country?
Maryland Montgomery Poolesville 106. Street and Number 107. Zip Code 109. Citizen of the street and Number 15511 Sugarland Road 20837 Unite	ed States
11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. F	Race - American Indian, Black,
Armed Forces? 1 Never Married 2 Married 1 Yes 2 No	White, etc.
1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: Spec	ecify.White
Specific of Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done) 16b. Kind of Market Specific or Dates: 17. Tes 2 (M) Specific or Dates: 18. Decedent's Usual Occupation (Give kind of work done)	of Business/Industry
9 10. Decedent's Education (Specify only highest grade completed) 15. Decedent's Education (Specify only highest grade completed) 15. Decedent's Could of Work and or Work done during most of working life. DO NOT use retired) 15. Decedent's Education (Give kind or work done during most of working life. DO NOT use retired) 15. Rind of during most of working life. DO NOT use retired 15. Rind of d	
Secretary Tec	chnology
18. Mother's Name (First, Middle, Last)	name)
Secretary Tec. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surn 18. Mother's Name (First, Middle, Maiden Surn 18. Mother's Name (First, Middle, Maiden Surn 18. Mother's Name (First, Middle, Maiden Surn 19. Delay	
Raymond Beckwith / Husband 15511 Sugarland Rd. Poolesville, M. 20a. Method of Disposition (Name of cemetery, Date 20c. Locat	Ation - City or Town, State
20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Locat March 24,	
20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other, Specify: 20b. Place of Disposition (Name of cemetery, crematory or other place) 4 Donation 5 Other, Specify: 21. Signature of Facility Resthaven Funeral Services, Skk	erick, Maryland
4 Donation 5 Other, Specify: Resthaven Crematory 2012 Frede 22. Name and Address of Facility Resthaven Funeral Services, Skk	kot Cody P.A.
Physician 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or	or heart Approximate Interval
failure. List only ope cause on each line.	Between Onset and
Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Intoxic	acton
Sequentially list conditions, b	
if any leading to immediate Drie to (or as a consequence of):	
if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dre tu (or as a consequence of): Dre tu (or as a consequence of):	
dd.	
3	
Proposed at time of death IF FEMALE: 23d. Dat 24d. Da	ate of delivery
So to the past 12 months? 1 Live birth past 12 months? 4 Pregnant at time of death 5 Other (Specify)	nth Day Year
Section Sect	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use c	contribute to the cause of death?
J. Yes 2 No	3 Probably 4 V Unknown
24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
24a. Was an autopsy performed? 1 Yes 2 No	death? 1 ✔ Yes 2 No
The state of Death (Check only one) 1 ✓ Yes 2 No 26.Place of Death (Check only one) 1 ✓ Yes 2 No	
24a. Was an autopsy performed? 1 V Yes 2 No 25. Was case referred to medical examiner? 1 V Yes 2 No 26. Place of Death (Check only one) 27. Manner of Death 28a. Days of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurrence of the property of the p	6 Other:
27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury or (Month, Day, Year)	
Solve to the subject took of the subject took of the subject took of the subject took of the subject took of the subject took of the subject took of the subject took of the subject took of the subject took	
So the determined of Death of Death of Highly at Work? So to be determined 1	umber or Rural Route Number, City 10 Grand Pre Rd.
4 Homicide determined (Specify) Found: Residence #103 Silver	Spring,MD.
🛱 🛪 😨 🛮 📆 (Check only 1 🗀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mar	
음 향 음 등 and manner stated.	signed (Month, Day, Year)
	15, 2012
i 30. Name and address of person who completed cause of death (Item 23a)	
30. Name and address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Lloyd Lee Beckstrom March 15, Day 2012 Year 4:18 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Frederick Kline Hospice House Mt. Airy Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthdav) 8. Date of Birth (Month, Day, Year, 9. Birthplace (State or Foreign **Funeral** 80 567-32-9627 Director July 27, 1931 California Usual Residence of Deced 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Frederick Maryland Frederick 1 Yes 2 X No o 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23a or the Medical Examiner must be r Funeral 21704 USA 599 Quinn Orchard Road 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 X Yes 2 No 1953 If Yes, Give Year or Dates. 1955 þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: white Completed 3 Nidowed 4 Divorced Specify: 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Sales Representative Vitamins should be filed with and Mental Hygier. other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnarne) Joseph Oscar Beckstrom Ethel Elek 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20874permit. Page 1 and 2 st Department of Health ar Important: If item 27 is any injury or are Jason Beckstrom - son 19521 Bowman Ridge Drive, Germantown, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Feremation 3 Removal from State Stauffer Crematory 3-16-2012 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) . Sign re of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) arkinson Medical Due to (or as a consequence of) Examiner Demen Sequentially list conditions Examine if any, leading to immediate Due to (or as a consequence of) death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) burialphysician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year Dav Pregnant at time of death 2 No 1 Yes 2 9 Unknown ed by the a detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician; The law page 2 Jas perform After this certificate 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) HOSPICE Hospital Other: HOUSE 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Natural injury 5 Pending after death. Director: Af 1 Yes 2 No Investigation filled in by the Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined Medical within 24 hou

To the Fune

completely fi 29a. Certifier 🛂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 3-17-17 MD D60417 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick MD 21702

State

Registrar

10 hoson

Dr.

Thomas

Registrar's Signatur

19

Am AA	end #10ap CO Health	er De			artment of Health and	-	•	
		-	State Registrar		tificate of Death	, ,	, No. 2012	10428
	Physicia Medic		1. Decedent's Name (First, Middle, Last) JAVE BEARD			2. Date of Death Month	Day 7017	3. Time of Death
Ô	Examir	er	4a. Facility Name (if not institution, give street and ANNE ARVNIE MENLA		4b. City, Town, or Location of Deat	h	4c. County of Death	
	Funeral	2)	Social Security Number 6. Sex	7. Age (In yrs. last birthday)	ANN HOUS If Under 1 Year I If Under 24 Hrs		9. Birth	whel
	Director		466-18-6709 1 □ M 2≹	91 _{Yrs.}	Months Days Hours Min.	(Month, Day, Ye, 8/22/19)	ear) Cour	ntry)
	and show	or	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loc	cation			10d. Inside City Limits
	Maryla 28a-f	irect	Maryalnd Anne Arunde	:1	Annapolis			1 🕱 Yes 2 🗆 No
	72 hours after death with the Maryland n'matural", or items 23a or 28a-f shov ledical Examiner must be notified at	Funeral Director	Maryland 10e. Street and Number	ood Road #110	10f. Zip Code 214(. Citizen of What Cou	ntry?
	ems 2	nue			Vas Decedent of Hispanic Origin? (S		USA 14. Race - Ameri	an India
36	'2 hours after death '"natural", or item edical Examiner n	by	1 Never Married 2 Married 1 Arm	ed Forces?	f Yes, specify Cuban, Mexican, Puert Yes 2 X No Specify:	o Rican, etc.)	Black, White,	etc.
00	ours a atural' cal Ex	Completed		or Dates.			Specify: Whi	te.
215	n 72 h e. an "na Medik	mpl	(Specify only highest grade comp	(Give A	lent's Usual Occupation kind of work done during most of wo DNOT use retired)	rking 161	b. Kind of Business/Ir	ndustry
21	filed within tal Hygiene. ed other than event, the M	Be Co		2 Home	emaker		Own Home	
Maryland 21215-0036	ge 1 and 2 should be filed within 72 hour it of Health and Mental Hygiene. If item 27 is marked other than "natur or other traumatic event, the Medical	To B	17. Father's Name (First, Middle, Last) Maurice D. Bryant			me (First, Middle, Maid aynell Mart		
, Mar	od 2 shou ealth and n 27 is n er traum		19a. Informant's Name/Relationship (Type, Print) Ledford Beard - Husba		g Address (Street and Number or Ru Edgewood rd, Ann			Code)
Baltimore,	permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra		20a. Method of Disposition 1 ☐ Burial 2 【X Cremation 3 ☐ Removal 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Dispos	sition (Name of	Date 200	c.Location - City or To altimore,	
altir	permit. Pag Departmen Important: any injury once.	1	21. Signature of Funeral Service Licensee		. Name and Address of Facility J_0			
æ	De E E E	_	Mylin (. Olit		47 Duke of Glouce			
	Physician/ Medical Examiner		23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	that caused the death. Do not ente on each line. ADL: AUEVI e to (or as a consequence of):	r the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
1	NIE II	iner	Sequentially list conditions, it at y, leading to immodule cause. Enter Underlying	e to (or as a consequence or).				
		I Examiner	Cause (Disease or injury that initiated events c.	e to (or as a consequence of):				
09		dica	d					
68760	eath certificate b attending physid for use as the k	M/M	IF FEMALE: 23c. If yes	, outcome of pregnancy			1	
). Box	that the death of	Physician/Medical	in the past 12 months?	Live Birth 2 Fetal death 3 Pregnant at time of death 5 Unknown	Ectopic pregnancy Other (specify)		23d. Date of deliv Month	Day Year
ds, P.O.	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. In the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	۾	Part II. Other significant conditions contributing	to death but not resulting in the ur	nderlying cause given in Part I.		co use contribute to the	. 1
Records,	sician: The law re certificate has be lirector, page 2 sh	Completed				24a. Was an autopsy performed	prior to co	psy findings available mpletion of cause of
	ysician: s certifici director,	Be	25. Was case referred to medical examiner?		26. Place of Death (Che		INO, I LI ICO	2 110
of Vital	Physi r this c eral dir	욘	Tes ZIA NO	1 Inpatient 2 ER/Outpatient Date of injury 28b, Time of	Other: 4 Nursing H		6 Other (Specify)
ion	tending Fleath. :or: After the funer	Certificate:		Month, Day, Year) injury	work? M 1 Yes 2 No	28d. Describe how in	njury occurred	
Division	tal or Attendin rs after death. al Director: Aft led in by the fu		4 Homicide determined 28e. F	Place of Injury - At home, farm, streeuilding, etc. (Specify)	et, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural ate)	Route Number,
	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical	(Check 2" Medical Examiner: On the	e basis of examination and/or investi-	ccurred at the time, date and place, gation, in my opinion, death occurred a death occurred at the time, date and p	at the time date and nla	ace and due to the car	ise(s) and manner stated
	To t To 1		29b. Signature and title of certifier	BINGIANI	29c. License number	29d.	Date signed (Month, 1	Day, Year)
	8/K		30. Name and address of person who completed	cause of death (Item 23a) (Type, Pr	int)		2 (11)0	
			11. Date filed (Month. Day, Year)	OL MENICAL D	ARKWAY, BUN	HPOUS, M	D 21401	
	State Registra	r	31. Date filed (Month, Day, Year) MAR 1 9 2012	Beaus A. A	all			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month \mathbf{a}_{M} Bowie 2012 5:00 Richard Melvin Medical March 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Atria Manresa Annapolis Anne Arundel If Under 1 Year If Under Months Days Hours 6 Sex 7. Age (In vrs. last birthday 8. Date of Birth **Funeral** Birthplace (State or Foreign Country) 1 M 2 □ F (Month, Day, Year) 11/19/1918 Months Min Director 212-12-2480 93 Washington.DC Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits **Funeral Director** notified 1 X Yes 2 ☐ No Maryland Anne Arundel Annapolis 10e. Street and Number ŏ 10f. Zip Code items 23a or ner must be n 10g. Citizen of What Country? 85 Manresa Road 21409 USA Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Examiner Black, White, etc. ò þ 1 Never Married 2 Married 1 X Yes 2 □ No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. "natural" 3 Midowed 4 Divorced Specify: Completed White of Health and Mental Hygiene.

item 27 is marked other than "natu other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Installer Western Electric Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Benjamin Otto Bowie Ethel Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a 20850-2060 139 Crofton Hill Lane Richard Malcolm Bowie/Son Rockville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date ò ₩ 5 1 🛮 Burial 2 🗆 Cremation 3 🗀 Removal from State Department or Important: If any injury or 4 Donation 5 Other (Specify) Fort Lincoln Cemetery 03/17/2012 Brentwood, Maryland permit. Sign Ture of Funeral Service Licenses 22. Name and Address of Facility Fort Lincoln Funeral Home 3401 Bladensburg Road Brentwood, MD 20722 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sheek, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Cardiac Arrhythmia Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (present or impury that initiated experts.) Due to (or as a consequence of): Exami that initiated events resulting in death) Last and Due to (or as a consequence of): anding physician are as the burial Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? ò Day Pregnant at time of death Month Year signed by the a d be detached f 9 Unknown 9 Unknown The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Failure to Thrive Completed 1 Yes 2 No 3 Probably 4 NonAmown After this certificate has been si funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No Yes 2 X No 9 Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certifica 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA $4 \, \overline{\mathbf{X}} \,$ Nursing Home $\, 5 \, \Box \,$ Residence $\, 6 \, \Box \,$ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work 2 Accident
3 Suicide
4 Homicide 1 Tes within 24 hours after death

To the Funeral Director: A
completed filled in by the f 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one 29b. Signature and title of 29c. License number 2 29d. Date signed (Month, Day, Year) D57028 March 15, 2012 ho completed cause of death (Item 23a) (Type, Print) Aditya Chopra Mo 600 Ridgely Ave. Ste. 231 Annapolis, MD 21401 31. Date filed (Month, Day, Year) State AR 2 0 2012 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Vear 10:22a^M Duayne Rodney Barr 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Adventist Hospital Takoma Park Montgomery 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Social Security Number 7. Age (In vrs. last birthday) Days 1 ★ M 2 □ F Min. Hours 64 Yrs Director 215-58-8552 1948 Usual Residence of Decedent 28a-f show should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director 1 X Yes 2 No MD Prince Georges Fort Washington 23a or 2 10f, Zip Code 10g. Citizen of What Country? Funeral 802 East Tantallon Drive 20744 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Bace - American Indian Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give Black, White, etc. "natural", or i Completed by 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Specify: Black Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Technician 2yrs. Washington Gas Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ Joseph Barr Doretta Peaks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 street of Health a Myron Barr/Son 10607 Lazyday Lane Mitchellville MD 20721 other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of I Important: If it cemetery, crematory or other place; 1 🖾 Burial 2 🗌 Cremation 3 Removal from State injury or 4 Donation 5 Other (Specify) 3-23-2012 Landover, Maryland 21. Signature of Funeral Se 22. Name and Address of Facility John T. Rhines Funeral Home 3005 12th Street NE Washington DC 20017 **4 L M** 101 a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Anoxic disease or condition Medical resulting in death) Examiner onWalon Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin burial-transit Cause (Disease or linjury that initiated events that the death certificate be executed COPD Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Year 4 Pregnant at time of death 9 Unknown signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 1 Yes 2 No Yes Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Other: 1 Yes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After 1 Natural injury 5 Pending 2 Accident 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 72441 MD no 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Menue

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Box 68760

Records,

Division of Vital

ar's Signature

32. Regis

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. for State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day $201\overset{\text{Year}}{2}$ Peggy Rose Pharaoh Butler March 16, 2220 hrs Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Fort Washington Medical Center Fort Washington 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 🗆 M 2 🗶 F Days Hours June 20, Year) New York 77 Director 121-24-4995 Usual Residence of Decedent shov 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits notified at Director 28a-f District of Columbia 1 X Yes 2 No Washington 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? must be Funeral 23a 4705 - 4th Street, N. W. 20011 United States items 2 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Examiner Black, White, etc. ŏ g 1 Never Married 2 Married ☐ Yes 2 **X** No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Native American If Yes, Give "natural", 3 X Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry I Hygiene. U.S.Federal Emergency Elementary/Seconday (0-12) College (1-4 or 5+) Management Agency should be filed with and Mental Hygien 7 is marked other th 12th grade Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Samue 1 Pharaoh Mary Brewer 19a. Informant's Name/Relationship (Type, Print) (Daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Jeanette Elaine Butler-Gray 4705 - 4th Street, N.W.; Washington, D.C. 20011 Date 22, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State MARCH SAG HARBOR, NEW YORK 4 Donation 5 Other (Specify) OAKLAND CEMETERY 2012 21. Signature of Fundal Service Licenses 22. Name and Address of Facility R. N. Horton Company Morticians, olis Inc.;600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 10 disease or condition resulting in death) Medical Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami that initiated events resulting in death) Last attending physician for use as the buria Physician/Medical requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Dav Pregnant at time of death the 9 Unknown 9 X Unknown been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the *u*nderlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy certificate 1 Yes 2 No Yes Hospital or Attending Physician: 1 24 hours after death. Funeral Director: After this certifica eted filled in by the funeral director, p 25. Was case ref d to examiner?

1 Yes 2 No medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 XNo ၉ 1 Nnpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred ۏ injury work? 1 X Natural 5 Pending Certificat Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours aft

To the Funeral Di

completed filled in Medical 🔼 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Norse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the 29b. Signature and title of certifi

State Registrar 31. Date filed (Month, Day, Year)

MAR & 1 2012

negistrar

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Obiora Ogbuawa; M.D.; 11701 Livingston Road; Suite 209; Fort Washington, Maryland

20744

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Depart	rtment of Health	h and Me	ental Hyg	giene	
			1 - State Registrar Cert	ificate of Death	h		Reg. No. 2	112 1043(
	Physicia	n/	1. Decedent's Name (First, Middle, Last)			2. Date of Dea		3. Time of Death
	Medic		Anna Josephine Benton			March	17, 2012	2 4:32P M
	Examin	er	2011 7 -	4b. City, Town, or Location			4c. County of	
•	s) Francost		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Temple Hills If Under 1 Year If Und		3. Date of Birti		e George's 9. Birthplace (State or Foreign
	Funeral Director		577 20 0200 LUNOWS	Months Days Hours	rs Min.	(Month, Day	(, Year)	Country)
la.			Usual Residence of Decedent			8/18/1	917	Pennsylvania
	yland f sho	ctor	10a. State 10b. County 10c. City, Town or Local					10d. Inside City Limits
	e Mar 28a- notifii	Director	Maryland Prince George's Temple Hil					1 ☐ Yes 2 🔀 No
	ith the	ral	2014 Jameson Street	10f. Zip Code 20748			10g. Citizen of W	/hat Country? USA
	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho er the Medical Examiner must be notified at	Funeral		as Decedent of Hispanic (Origin? (Specif	v Yes or No-	14 Page	e - American Indian,
9	or it	by F	Armed Forces? If Y	Yes, specify Cuban, Mexic	ican, Puerto Ric	can, etc.)	Black	k, White, etc.
8	ırs aft ural", I Exa	led I	3 Widowed 4 Divorced If Yes, Give Year or Dates.	☐ Yes 2 X No Speci	cify:		Specify:	White
2-	2 hou "nat edica	Completed	(Specify only highest grade completed) (Give kir	nt's Usual Occupation nd of work done during m	nost of working		16b. Kind of Bus	siness/Industry
12	ithin 7 ene. than he M	Son	Elementary/Secondary (U-12) College (1-4 or 5+)	NOT use retired)				
ი ნ	Hygid Hygid Other ent, t	Be	17. Father's Name (First, Middle, Last)	Telephone C	_		<u> </u>	of Defense
Maryland 21215-0036	should be filed v h and Mental Hyg 7 is marked othe traumatic event,	으	Frank Benton		ary E.	Rei		
ary	hould and M s ma		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing	Address (Street and Num				ate, Zip Code)
	and 2 s Health a em 27 i		Eleanor Barber/Sister 2014	Jameson St.	. Temple	e Hill:	s, MD 20	748
ore	e 1 ar of Hi If iter		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition cemetery, cremation 3 ☐ Removal from State	tion (Name of tory or other place)	Dat	- 1	20c. Location - 0	City or Town, State
<u>Ē</u> .	Page tment c tant: If jury or		4 Donation 5 Other (Specify) Gate of H		3/21/2	2012	Silver S	Spring, MD
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.			Name and Address of Factors 60 Oxon Hill				
			23a. Part Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.					Approximate
	PHYMEINS/		Immediate Cause (Final disease or condition MALIGNANT MELANCE)	OMA				Interval Between Onset and Death Months
	Medical Examiner		resulting in death) Due to (or as a consequence of):					1 110110110
		Ţ.	Sequentially list conditions, b.					
	sit sit	Examiner	if any, leading to immediate Due to (or as a consequence of): cause: Ente. 'underlying' Cause (Disease or injury					
	certificate be executed inding physician and use as the burial-transit	Exal	that initiated events resulting in death) Last Due to (or as a consequence of):					
0	be ey siciar burik	edical						
3760	ficate g phy as the						1	
89	requires that the death certific been signed by the attending should be detached for use as	by Physician/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1	Ectopic pregnancy			23d. Date	e of delivery
Box	death he atte	sici		Other (specify)			Mon	nth Day Year
o.	iaw requires that the ras been signed by the e 2 should be detach	Phy	Part II. Other significant conditions contributing to death but not resulting in the unc	tortuing course given in Pa	art I	00 - 0:44		
ď.	es th	d b	That is the significant conditions contained in a case of the conditions are the conditions and the conditions are the conditio	errying cause given in Fa	art i.	1 \(\text{Y}		bute to the cause of death? 3 Probably 4 Unknown
ğ	requir	etec						
ပ္ပ	sician: The law r certificate has b lirector, page 2 s	Completed				24a. Was a autops perfor	sy pr	/ere autopsy findings available rior to completion of cause of eath?
<u> </u>	n: The lificate h		25. Was case referred to medical	26 Place of D	Charles	perfor	2 X No 1	Yes 2 No
Ita	s cert	To Be	examiner? 1 Yes 2 X No Hospital: 1 Inpatient 2 ER/Outpatient	_ Other: _	Death (Check or		C 🗆 O#	(0
0	g Phy er this neral o		27. Manner of Death 28a. Date of injury 28b. Time of	28c. Injury at			ence 6 Other ow injury occurred	
on	ath. r: Aft	licat	1 🛣 Natural 5 □ Pending (Month, Ďay, Year) injury 2 □ Accident Investigation	work? M 1 ☐ Yes 2	□ No			
Division of Vital Records,	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street building, etc. (Specify)	t, factory, office	28f	f. Location (St City or Town		r or Rural Route Number,
	ospita hours uneral	Medical	29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occ					
	the H nin 24 the Fu	Me	(Check 2 ☐ Medical Examiner: On the basis of examination and/or investign only one) 3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, de					
_	To with		29b. Signature and title of certifier	29c. License number	_	1	- i	(Month, Day, Year)
	5		1 / Clee	MD036	186		3/19	12012
	Ja Ja			Trving St.	N.W. V	Washing	gton, DC	20010
	Stat Registra	_	31. Date filed (Month, Day, Year) 32. Registrar's Signature 34. Aparthus					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Lloyd R. Christopher 20, March 2012 7:50 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 520 N. Washington Street Talbot Easton Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours (Month, Day, Year 7 / 1 7 / 1 3 218-07-251 Yrs. Director 98 Maryland Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits 1 X Yes 2 No Easton MD Talbot 10e. Street and Number 10f. Zip Code ms 23a or must be n 10g. Citizen of What Country? Funeral 520 N. Washington Street 21601 United States 12. Was Decedent Ever in U.S. 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Examiner Armed Forces Black, White, etc. ò Completed by 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: "natural" 3 X Widowed 4 ☐ Divorced White the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Auto Dealers Auto Mechanic other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fishers is marked or ပ William Richard Christopher Suda Frances Hopkins . Page 1 and 2 should be treent of Health and Men tant: If item 27 is marke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Lee McGrath/Niece 407 Noble St., Hurlock, MD 21643 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or o once. 1X Burial 2 Cremation 3 Removal from State Firemen's Cemetery 03/23/12 Sharptown, Maryland Donation 5 Other (Specify) 22. Name and Address of Facility Framptom Funeral Home, P.A. 21. Signature of Funeral Service Licenses 216 N. Main St., Federalsburg, MD 21632 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ inani disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): the Hospital or Attending Physician; The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year Pregnant at time of death been signed by the should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DIAMETER MELLITUS 1 Yes 2 No 3 Probably 4 Unknown 124 HEROSZERD FIC CAMPIDYAKKIAN 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death? within 24 hours after death. To the Funeral Director. After this certificate has I completed filled in by the funeral director, page 2 ϵ 1 Yes 2 No æ 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 은 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending ☐ Accident ☐ Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 🚅 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of ce 20 Name and address of person completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 Richard W. Collins 18:25 March Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Dorchester East New Market 5740 Linkwood Road Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🔀 M 2 🗆 F Months Hours 212-56-1035 Director 60 1951 Maryland Usual Residence of Decedent show item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director East New Market MD Dorchester 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5740 Linkwood Road 21631 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2√ No Specify: If Yes, Give White 3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) id Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Trucking 12 Office Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Walter R. Collins Emily Moore Page 1 and 2 should and lis m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cathy C. Collins/Spouse item 27 5740 Linkwood Rd., East New Market, MD 21631 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State Department of Important: If it any injury or o 1 Durial 2X Cremation 3 Removal from State Cambridge, Maryland 03/12/12 Mid Shore Cremation Ctr. 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Framptom Funeral Home, P.A. 216 N. Main St., Federalsburg, MD 21632 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final ∳nysician/ UNG CANCER disease or condition resulting in death) **Medical** Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) nding physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical requires that the death certificate be Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year 1 L Yes 2 L 9 Unknown 9 Unknown P.O. I is been signed by the should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law 124 hours after death.
Funeral Director: After this certificate has b autopsy page 2 2 🗌 No 1 Yes 25. Was case referred to medical examiner?

1 Yes 2 No completed filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital ၉ 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury 5 Pending work?
1 Yes 2 No ☐ Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a Medical 29a. Certifier certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) To the 29b. Signato 29d. Date signed (Month, Day, Year)

ICH

DHMH 17 Rev 7/2009

State Registrar Name and address of person who completed cause of death (Item 23a) (Type, Print)

8221

strar's Signature

SMITH

DAVID

31. Date filed (Month, Day, Year)

D39887

TEAL DRIVE, SUITE 302, EASTON, MA 21601

2012

12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Eller Boswell Clohessy Connors 7. March 3:15 P ^M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George's Hospital Center Cheverly Prince George's 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Min Hours 579-03-5591 **Director** 1 □ M 2 🗶 F 92 07/14/1919 Washington, DC Usual Residence of Decedent . Hygiene. other than "natural", or items 23a or 28a-f show rent, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🛣 No MD St. Mary's Charlotte Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 37720 Mohawk Drive 20622 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc þ 1 Never Married 2 Married 1 Yes 2 No Specify. If Yes, Give Year or Dates 3 Midowed 4 ☐ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Doctor's Office llth Office Manager is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Unknown Joseph Boswell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 37720 Mohawk Drive Charlotte Hall, MD 20622 Patricia Clohessy-Groson/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Brinsfield-Echols Fun 03/16/2012 Charlotte Hall, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Brinsfield-Echols F.H., P.A. M00817 Ec 30195 Three Notch Rd., Charlotte Hall, MD 20622 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heard failure. List only one cause on each line. such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician. Closed disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examiner If any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events and resulting in death) Last Due to (or as a consequence of) attending physician at for use as the burial Physician/Medical To the Hospital or Attending Physician; The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Unknown the 9 Unknown ģ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy perform certificate 2 No 1 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner2 Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work?
1 \(\subseteq \text{Yes} \) STAIRS MARCH 6 700 1707M within 24 hours after death

To the Funeral Director: / 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 37720 Mohawk Drive Charlotte Hall, MD 20622 determined home

Records, Division of Vital

Box 68760

P.O.

Maryland 21215-0036

Baltimore,

State Registrar

Medical

29a. Certifier (Check

3

29b. Signature and title of certifier

3001 Hos 31. Date filed (Month, Day, Year

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Nurse Practitioner: To the best of my lend

32. Registrar's Signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month. Dav. Year)

	T = For State Registrar		Certificate of Deat	th and Mental Hy h	Reg. No. 2	12 1043
Physician/ Medical	Decedent's Name (First, Middle, Last) Charles Will		oin	2. Date of D Month March	Day	3. Time of Death 3:50 a
Examiner	4a. Facility Name (if not institution, give street and 38799 Morris Point		4b. City, Town, or Locati	on of Death	4c. County	of Death Mary s
Funeral Director	5. Social Security Number 578-44-8366 Usual Residence of Decedent	7. Age (In yrs. last birthda	Months Days Hou	, , ,	ay, Year)	9. Birthplace (State or Foreig Country) Washington, DO
Maryland 28a-f show otified at rector	10a. State 10b. County Maryland St. Mary	10c. City, Town or	Location			10d. Inside City Limi
seath with the Maryland items 23a or 28a-f shuer must be notified at Funeral Director	10e. Street and Number 38799 Morris Point		10f. Zip Code 20606			What Country?
irs after deat ural", or iten Examiner i ed by Fu	1 Never Married 2 Married 1 If Yes	Decedent Ever in U.S. 1 d Forces? Yes 2 M No s, Give or Dates.	 Was Decedent of Hispanic If Yes, specify Cuban, Mex Yes 2 No Spe 		- 14. Rac Blac Specify:	e - American Indian, ck, White, etc. White
within 72 hours after or giene. ler than "natural", or the Medical Examir.	15. Decedent's Education (Specify only highest grade complete the complete that the	eted) (G.	cedent's Usual Occupation ive kind of work done during r b. DO NOT use retired)	nost of working		usiness/Industry
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	11. 17. Father's Name (First, Middle, Last) George Corbin			other's Name (First, Middle	·	*
nd 2 shoul ealth and I m 27 is m er traum:	19a. Informant's Name/Relationship (Type, Print) Chalres M. Corbin/Son		ailing Address (Street and Nu			·
permit. Page 1 and Department of Hea mportant: If item any injury or othe	20a. Method of Disposition 1 ♣ Burial 2 ☐ Cremation 3 ☐ Removal 4 ☐ Donation 5 ☐ Other (Specify)	from State cemetery, of	sposition (Name of crematory or other place) ston National	7/23/2012	Suitla	City or Town, State
permit Depar Impor any in	21 Signature of Funeral Service Auch all Jarol 23a. Part 1. Enter the disease, or complications to	iner	22 Name and Address of Fe Mattingley—G 41590 Fenwic	k St., Leona	rdtown,	P.A. MD 20650
redificate be executed axa bridge physician and assess the burial-transit and are well as the burial-transit and are well as a second and are are a second as a second and are are a second as a second and are are a second and are a second as a second and are a second and a second and are a second and are a second and are a second and a second and a second and a second and a second and a second a	resulting in death) Sequentially list conditions, if by 193 g to medicit cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d	e to (or as a consequence of): e to (or as a consequence of):	ARTERY	V1>EH>E		
the death certifica by the attending platached for use as the attended for use as the physician/Me	in the past 12 months?	a, outcome of pregnancy Live Birth 2 ☐ Fetal death Pregnant at time of death Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Da Mo	te of delivery nth Day Year
The law requires that the deracte has been signed by the page 2 should be detached Completed by Physic	Part II. Other significant conditions contributing DEMENTIA	to death but not resulting in th	ne underlying cause given in P			ibute to the cause of death? 3 Probably 4 Unknown
rician: The law r s certificate has b director, page 2 sl	25. Was case referred to medical		26 Place of I	24a. Was auto perfi 1 Yes Death (Check only one)	opsy pormed?	Were autopsy findings availab orior to completion of cause of death? I ☐ Yes 2 ★No
ng Physician: T tter this certifica uneral director, g	27. Manner of Death 28a. I	1 ☐ Inpatient 2 ☐ ER/Outpa Date of injury 28b. Time Month, Day, Year) 28b. Time injur	tient 3 □ DOA Other: 4 □ e of y 28c. Injury at work? 1 □ Yes 2	Nursing Home 5 Resi	how injury occurre	ed
ttendii death. tor: Ai the fu	3 Suicide 6 Could not be				Street and Numbe wn, State)	er or Rural Route Number,
ospital or Attending P hours after death. Ineral Director: After the filled in by the funeral dical Certificate:	4 ☐ Homicide determined 28e. ☐ 29a. Certifier 1 ★ Certifying Physician: To t	Place of Injury - At home, farm, uilding, etc. (Specify) the best of my knowledge, dea	th occurred at the time, date	and place, and due to the c	ause(s) and mann	er as stated.
To the Hospital or Attending Ph Within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Medical Certificate:	4 ☐ Homicide determined 28e. ☐ 29a. Certifier 1 ★ Certifying Physician: To t	uilding, etc. (Specify) the best of my knowledge, dea basis of examination and/or inv oner: To the best of my knowlec	th occurred at the time, date a	and place, and due to the c h occurred at the time, date date and place, and due to	and place, and due the cause(s) and m	e to the cause(s) and manner sta
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi Medical Certificate: To Be Completed by Physician/Medical Exam	4 Homicide determined 28e. B 29a. Certifier (Check only one) 1 Certifying Physician: To the only one) 3 Certifying Nurse Practition 29b. Signature and title of certifier	cause of death (Item 23a) (Type	th occurred at the time, date a vestigation, in my opinion, deat lge, death occurred at the time 29c. License numbrane D 5 3 8	and place, and due to the choccurred at the time, date date and place, and due to er	and place, and due the cause(s) and m 29d. Date signed	e to the cause(s) and manner stananner as stated. Id (Mo nt h, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 1 Walter Haycock Cusick Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death FutureCare Pineview Clinton Prince George's Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months Days Min Year) Hours **Director** 579-36-3887 1 🛣 M 2 🗌 F 81 Yrs. 12/24/1930 Washington, DC Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If item 27 is amarked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland St. Mary's Avenue 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20609 21250 Georges Lane USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, rmed Forces?

X Yes 2 \(\subseteq \) No Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🛣 No Specify. Completed 3 Divorced 4 Divorced Specify. White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Courier Gas Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Marguerite Haycock Walter Cusick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 473, Avenue, MD 20609 Joan Warczynski/Sister-in-law 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 x Burial 2 Cremation 3 Removal from State 3/15/2012 4 ☐ Donation 5 ☐ Other (Specify) Sacred Heart Bushwood, MD 21. Signature Name and Address of Facility
Mattingley-Gardiner Funeral Home, P.A.
41590 Fenwick St., Leonardtown, MD 20650 David A. Goff ease, or comp e. List only on 23a. Parl 1. Enter the di shock, or heart fail rrest, one cause on, each line. Approximate Interval Between Onset and Death Immediate Cause (Fi Physician/ disease or condition nu MOTICHO WAY Medical resulting in death) (or as a consequence of) **Examiner** MOT KNAWA Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Due to (or as a consequence Examin Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician; The law requires that the death certificate be executed burial-trans Due to (or as a consequence of): Physician/Medical Box 68760 nding physics as the last as t use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No for Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown been signal 24b. Were autopsy findings available prior to completion of cause of 24a. Was an s certificate has b director, page 2 s death? 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 200 Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Acciden work?
1 Yes 2 No 5 Pending within 24 hours after death

To the Funeral Director: / Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical

DHMH 17 Rev 06-2011

State

Registrar

29a. Certifier (Check

29b. Signature and itle of certifier

31. Date filed (Month, Day, Year)

M

MAR 19

30. Name and address of person who sympleted cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

0058 170

Cettifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 03 Physician/ SHIRLEY ANN CAREY 0 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Wicomico Peninsula Regional Medical alisbur (CONTC) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months 5-20-1942 Hours 221-26-8604 Director DELAWARE 1 □ M 2 💢 F 69 Usual Residence of Decedent show ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director SUSSEX DELAWARE SELBYVILLE 1X Yes 2 No 10f. Zip Code 10g. Citizen of What Country? Funeral 201 HOLLY GROVE LANE, UNIT 54 19975 US permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natures" any injury or other transmission. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 💢 No Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: If Yes, Give Specify: WHITE 3 Widowed 4 X Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) BOOKKEEPER AUTOMOTIVE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည OSCAR BIDDLE DORA COLLISON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHARON L. MEARS/DAUGHTER 30361 VINES CREEK RD, DAGSBORO, DE. 19939 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other) Date 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State MELSON'S CREMATORY 3-16-2012 4 Donation 5 Other (Specify) FRANKFORD, DELAWARE 22. Name and Address of Facility
MELSON FUNERAL SERVICES, LTD THATCHER STREET, FRANKFORD DELAWARE, 19945 Approximate 1. Enter the k, or heart f r the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, eart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician) disease or condition 1 Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) burial-tran Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Hospital or Attending Physician; The law requires that the death in the past 12 Month Day Year Pregnant at time of death 1 Yes 2 No the q Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate has performed? Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital 2 🛛 No Other: 1 Tes မြ 1 X Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending work death. 1 🔲 Yes 2 🗌 No Accident Investigation Funeral Director: 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of cert 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anthony BA4 Fley 100 E. CATTOI 31. Date filed (Mont. 32. Redistrar's Signature State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Evelyn Phillips Cheesman Medical 0.0 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4225 East New Market-Rhodesdale Road East New Market Dorchester 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral 216-07-7078 Director 1 □ M 2 🗓 F 95 Mar. 25, 1916 Maryland Usual Residence of Deced 28a-f show 10a State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 ី No Maryland Dorchester East New Market ò 10e. Street and Number 10f. Zip Code ms 23a or must be r 10g. Citizen of What Country? Funeral 4225 East New Market-Rhodesdale Road 21631 USA items , 11. Marital Status 12 Was Decedent Ever in LLS Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Medical Examiner Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: "natural", 3 X Widowed 4 □ Divorced White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) q q Homemaker Own Home event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Department of Health and Ment Important: If item 27 is marke any injury or other traumatic e Walter Augustus Phillips Nancy Olivia Short 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $\,\mathrm{MD}21631$ Thomas E. Cheesman, Jr./Son 4251 East New Mkt-Rhodesdale Rd., East New Market 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State East New Market Cemetery 3/22/2012 East New Market, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signal r of Frineral Service Licen Zeller Funeral Home, P. O. Box 207 106 Main Street, East New Market, 23a. Pard 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician BALEN disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed and -trai resulting in death) Last Due to (or as a consequence of): burialattending physician Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No ō Month Year Pregnant at time of death Day the 9 Unknown 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 No has certificate 1 Yes 2 1 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 2 No Other: 1 Tes မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 5 Pending work? 1 ☐ Yes 2 ☐ No ours after death.

leral Director: Aft
filled in by the fu Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 24 hours e Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Endedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the only one) Name and address of person who completed cause of death (Item 23a) (Type, Print) 160 COA

State Registrar AU

31. Date filed (Month, Day, Year)

Registrar's Signature

20

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ **JANET** 2012 CHAPMAN March 5:25 Medical A^{M} 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death <u>Frederick Memorial Hospital</u> Frederick Frederick **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 300-10-3017 Year) 1917 1 □ M 2🛣 F July 26, 94 Months Director Ohio Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Frederick Frederick 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 990 Waterford Drive 21702 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 should be filed within 72 hours aft and Mental Hygiene. is marked other than "natural", 1 Yes 2 X No Specify: 3₺ Widowed 4 □ Divorced white Completed Specify: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Retail accounting Department Store Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Leo Lucken Norma Goetz permit. Page 1 and 2 should Department of Health and Me Important. If item 27 is mar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Harrigan - daughter 2107 Garfield Court, Frederick, Maryland 21702 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🗆 Burial 2 🗓 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Stauffer Crematory 3-14-2012 Frederick, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility any Stauffer Funeral Home Maron Camelle 1621 Opossumtown PIke, Frederick, Maryland 21702 23a. Part 1. Enter the lisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner 1 day namenia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): burial-Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 🗆 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) Month 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Chronic Afrial Fibrilation Dementia Records, 1 Yes 2 No 3 Probably 4 Unknown Vasculor Minax 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law funeral director, page 2 autopsy performed? Yes 2 No 2 🗌 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Nation 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work s after death. 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State e Funeral L Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 □ To the within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8 400 31. Date filed (Month, Day, Year) 32. Registrar's Signature 16

DHMH 17 Rev 7/2009

Registrar

Box 68760

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State Registrar	of Marylar		artment tificate			ınd M		jiene ,	2012	10439
	Physici	an	Decedent's Name (First, Middle, Last)							2. Date of Dea Month	th Day	Year	3. Time of Death
A.	/Medic	al	JULIA ANN BATARLA CUI							MARCH	12	2012	10:00 A ^M
4	Examin	er	4a. Facility Name (If not institution, give street and ST. CATHERINE SNURSIN					Location o	f Death			ounty of Death	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.		EMM.		UKG If Under 2	24 Hrs.	8. Date of Birth		REDERIC 9. Birth	
	Director		072-07-2591 1□M 2 M		Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day MAY 24.		Cou	place (State or Foreign intry) NEW YORK
	pud 🔭		Usual Residence of Decedent 10a. State 10b. County	10c Ci	ity, Town or Lo	ontion							
	Aaryla f eho	5				Cation							10d. Inside City Limits 1 2 Yes 2 □ No
	28a-	rect	MARYLAND FREDERICK 10e. Street and Number	TH	URMONT	10f. Zip	Code			1	Oa. Citize	en of What Cou	intry?
	hours after death with the Maryland lurel', or Itame 23a or 28a-f ehow at Examinat mast be notified at	ai D	315 NORTH CHURCH STREE	Т		2178	88				U.S		,
	ame a	ner		ecedent Ever in U Forces?		Nas Deced	ent of Hi	spanic Orig	gin? (Spe	cify Yes or No- Rican, etc.)		Race - Amer Black, White	
36	or it	y Fu	1 Never Married 2 Married 1 Yes	s 2 No Give		1 🗆 Yes 2		Specify:	, r worto	noun, etc.)		Specify:	, etc.
21215-0036	fure!	Completed by Funeral Directo	3 Na Widowed 4 □ Divorced Year of Yea	or Dates:	16a. Deced	tont's House	I Occupa	tion				WH	ITE
7.	n nat	plet	(Specify only highest grade complete		(Give	kind of wor DO NOT us	k done d	urina most	of workii	ng	160. Kind	d of Business/li	ndustry
212	e filed within al Hygiene. I other then *	mo.	Elementary/Secondary (0-12) Colleg	e (1-4or 5+)		HOME	EMAKI	ER				- HOME	
pu	be filed within 72 hours after death with the Marylan Ital Hygiene. ad other than "naturel", or iteme 23s or 28s-f ehow event, the Madical Examinar mail be notified at	Be	17. Father's Name (First, Middle, Last)					18. Mother	r's Name	(First, Middle,	Maiden S		
<u>ya</u>	should be nd Menta markad umatic ev	၉	ADAM (NMI) BATARLA							(NMI)			-
Maryland	2 g = 1		19a. Informant's Name/Relationship (Type, Print) DANIEL M. CUDDAHEE / S	OM									^(p Code) 21798
	is 1 and of Health item 27 other to		20a. Method of Disposition	ON 20b. I	Place of Dispo	sition (Nam	ne of			RSTOWN :		WOODSB ation - City or T	ORO, MD.
Baltimore,	Pages nent of int: If it		1 Burial 2 Cremation 3 Removal fr 4 Donation 5 Other (Specify)	om State	cemetery, cren	natory or ot	her place		2/1/	/2010		•	
a E	그 문문을 .	1	21. Signature of Funeral Service Licenses	l Sri	ITHSBUF					/2012 FRT F	DATII	ISBURG.	MARYLAND N F.H.,P.A.
m	Depa Depa Impo any Ir		* Kultzx	111									AND 21788
			23a. Part1. Enter the disease, or complications the shock, or heart failure. List only one cause of	at caused the dea	th. Do not ent	er the mode	of dying	, such as	cardiac o	r respiratory arr	est,	THICLE	Approximate Interval Between
j	Physician		Immediate Cause (Final disease or condition	2 Com	1090	bu	e	80	QS	8'.8			Onset and Death
	/Medical Examiner		resulting in death)	to (or as a consec	quence/of):		1		1				
	18	70	Sequentially list conditions, if any, leading to immediate	to (or as a consec	- OZA	0	he	oni	C	•			
	uted I Insit	Examiner	Cause (Diseese or injury	10 (0) 43 4 00/1360	OL	101.	ec	73	7	1	2		
oʻ	te be executed ysician and e burial-transit		that initiated events resulting in death) Last C. Due	to (or as a consec	quence of):								
68760,		ical	d										
39 X	The law requires that the death certifica lie has been signed by the atlending ph bage 2 should be detached for use as it	Physician/Med	IF FEMALE:										
Вох	attend for us	lan/	in the past 12 months?	outcome of pregn. re birth 2 Feta	al death 3□	Ectopic pre					23	d. Date of deliving	very Day Year
o.	the de	ysic	1 Yes 2 No 4 Pr	egnant at time of on hknown	death 5∟	Other (spe	ecify)						54, 752.
S, G	that		Part II. Other significant conditions contributing t	o death but not res	sulting in the u	nderlying ca	ause give	n in Part I.		23e. Did to	bacco us	e contribute to	the cause of death?
rds	quires an sign uld be	ed by	Domen/1a	- M.	xe.	1				1 🗆 Y	es 2 🗆	No 3 ☐ Pro	bably 4 []Unknown
ဝွ	aw re	plet	Conquerya	ter +	Dis	3 200	-1	1		24a. Was a		24b. Were aut	opsy findings available ompletion of cause of
Vital Record		Completed	Chronic Kid	ine of	D13.	00	· l			autops perfor	med?	prior to co death? 1 ☐ Yes	
/ita	iician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?		7			26. Place	of Death	Check only or			
6	Physic this c	၉	1 ☐ Yes 2 No Hospital: 1		ER/Outpatien		1	4 Nur		ne 5□Resid			rfy)
חס	ding I h. After funer	tion	1 Natural 5 ☐ Pending (A	ate of Injury fonth, Day Year)	28b. Time of Injury	м 2	Bc. Injury Work	at ? ′es 2∐N		28d. Describe h	ow injury	occurred	
Division	Atten deat ctor: y the	fica	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Pl	ace of Injury - At h	ome, farm, str			63 2		28f. Location (S	treet and	Number or Rui	ral Route Number,
Ö	s after	Certification:	4 Homicide	ulding, etc. (Speci	fy)	,				City or Tow	n, State)		
	To the Hospital or Attending Physician: whin 24 hours after deals as a feet deals To the Funeral Director: Attenthis certifica completely filled in by the funeral director.	edical (29a. Certifier 12 Certifying Physician: To (Check only one) 12 Medical Examiner: On the and n	the best of my kno e basis of examina anner stated.	owledge deall ation and/or inv	ochumed a vestigation,	in my op	e, data and inion, deat	d plane, s th occurre	ind dua to the c ed at the time, o	3450(8) 3 late and p	nd rianner as place, and due	stated to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	10-0-		29c.	License	number		. 2	9d. Date	signed (Month	, Day, Year)
			Dodin Kon	FISI	00	1	10	74	10	3) 10	3-	12-	2012
	1	1	30 Name and address of person who completed o	a e of death (Iter	m 23a) (Type,	Print)	1	21-1	23	wood	- 11	17in	5/4 ee C
			31. Date filed (Month, Day, Year) 3	the-fa	RILL	140	2 5	illi	u:]	35 mg	h	100	202)
	Sta Registr		MAR 1 6 2012	Registrar's Sign	A. A	barks	1		,	U			. /

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Leonard Francis Clukey 1:50 a M March 15, 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
Frederick **Examiner** St. Joseph's Ministries Emmitsburg Social Security Number Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗙 M 2 🗌 Months Days Hours JUInth 1Pay Maine Year 936 75 006-34-0172 Director Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Thurmont Frederick Maryland 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21788 11 Mantle Court USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Yes. Give white 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Counseling Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Rosa Mountain Frederick Clukey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11 Mantle Court, Thurmont, MD 21788 Betty Baker, sister 20a, Method of Disposition 20b. Place of Disposition (Name 20c. Location - City or Town, State Department of F Important: If ite any injury or oth New Sty, credosephers (ace) 1 ★ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 3/19/2012 Emmitsburg, MD Catholic Cemetery Signature of Funeral Service Licensee 22. Name and Address of Facility Myers-Durboraw Funeral Home 210 W Main St, Emmitsburg, MD 21727 Part 1 Enter the disease, or complications that caused the death. shock, or heart failure. List only one could not be a complete. Do not enter the mode of dying Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (o Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last physician Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy in the past 12 months? Pregnant at time of death ę Month 5 Other (specify) Yes 2 No signed by the aid be detached for 9 Unknown 9 Unknown Other significant conditions contributing to death but not resulting in the enderlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perforn 1 Yes 2 No 25. Was case referred to medical examiner? Be funeral director, 26. Place of Death (Check only one) 1 🗆 Yes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, Manner of Dea 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural iniury 5 Pending Accident Investigation after death 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, g 4 Homicide determined within 24 hours after

To the Funeral Directory

completed filled in by Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the only one 29b. Signature and tit who completed cause of death (Item 23a) (Type Name and address of pe 31. Date filed (Month, Day, Year) Registrar's Signature State 19 MAR Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 15, Day 2012 Carmela Coluzzi 10:55 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Spa Creek Nursing and Rehab Anne Arundel Annapolis 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Hours **Director** 087-18-8505 91 1 M 2 X F 10/3/1920 Italy Usual Residence of Decedent with the Maryland 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director notified Maryland Anne Arundel Annapolis 28a-f 1 X Yes 2 No ō 10e. Street and Numbe 10f. Zip Code ms 23a or must be 10g. Citizen of What Country? Funeral 35 Milkshake Lane 21403 Usa 11, Marital Status 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Armed Force Black White etc and 2 should be filed within 72 hours after. Health and Mental Hygiene. tem 27 is marked other than "natural", or other traumatic event, the Medical Examir by 1 Never Married 2 Married ☐ Yes 2**X** No Specify: White 1 Yes 2 X No Specify Completed Yes. Give 3 x Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Food Service Worker General Electric Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 10 Salvatore Russo Elena Gilotti 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Theresa Wellman - Daughter 317 Elderwood Ct, Annapolis, MD 21401 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 Burial 2 Cremation 3 Removal from State ō permit. Page Department or Important: If any injury or 4 Donation 5 Other (Specify) Hillcrest Mem Gardens 3/17/2012 | Annapolis, MD Signature of Funeral Service Lice 22. Name and Address of Facility John M. Taylor Funeral Home McDist West 147 Duke of Gloucester St, Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ remove disease or condition Medical resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) burial-transi and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical as the IF FEMALE: nse yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 conths?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year ed by the a 1 Yes 2 L 9 Unknown 9 Unknown ate has been signed I page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ♣No 3 ☐ Probably 4 ☐ Unknown available Be

Examiner law requires that the death certificate be Box 68760 Division of Vital Records, P.O. certificate has Hospital or Attending Physician: The To the Hospital or Attending Phy within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral or

Baltimore, Maryland 21215-0036

		24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No
5. Was case referred to medical examiner?	26. Place of Death (Check onl	ly оле)
1 ☐ Yes 2 ▶ No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home	5 Residence 6 Other (Specify)
7. Manner of Death Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? M 1 Yes 2 No	. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office 28f.	Location (Street and Number or Rural Route Num. City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

, Dorch Drum

29d. Date signed (Month, Day, Year)

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

31. Date filed (Month, Day, Year) State Registrar

ဂ္

Certificate:

Medical

29a. Certifie (Check

29b. Signature and Me

oo completed cause of death (Item 23a) (Type, Print) 0-

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MARCH Physician/ 16^{3y} 2012 4:42 PM DIQUAN NIAHEEM CARTER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** NATIONAL INSTITUTES OF HEALTH MONTGOMERY BETHESDA if Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country)
 TTA Social Security Numbe 7. Age (In yrs. last birthday) Funeral Days Min. 230-69-3082 1 **X** M 2 □ F Months Hours 1(Month Pay Year) 3 Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location the Medical Examiner must be notified at Director 1 🗆 Yes 2 🖺 No NORFOLK VΑ 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 6 23513 23a Funeral 976 AVENUE F US hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc 1 Never Married 2 Married ō 1 ☐ Yes 2 💢 No If Yes, Give þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: "natural", 3 Divorced 4 Divorced BLACK Completed Year or Dates. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) SCHOOL SYSTEM STUDENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ ERICA WILKINS WAYNE CARTER 9'91 3aiiwenhurst Drive; Glenn Mallen; Tva S23060° 976 avenue f, norfolk, va 23513 MAYNE CARTER/FATHER Print) ERICA WILKINS/MOTHER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🖺 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) ROOSEVELT MEMORIAL PARK 3-24-12 22. Name and Address of Facility POPE FUNERAL HOMES, P.A. 21. Signature of Funeral Service Lig 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. MOIDST5538 MARLBORO PIKE, FORESTVILLE, MD 20747 Approximate Interval Between of right fibula metastatic to lungs Onset and Death Immediate Cause (Final Physician/ Osteosarcoma disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed?

1 Yes 2 No To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No 1 Tes ည 1 XInpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No 5 Pending injury 1 Natural Accident Investigation 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

Registrar DHMH 17 Rev 7/2009 (Check

only one 29b. Signature and

31. Date filed (Month, Day, Year)

MAR & U 2012

Jaka

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MELINDA MERCHANT

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

237660

3

10 CENTER DRIVE, BETHESDA, MARYLAND 20892

16

2012

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ March Dona₁d DeRidder Frederick 20 1°2 7:30 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 15287 Westbridge Court Henderson Caroline Social Security Numbe If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 🕅 M 2 🗆 F Days June 28 1960 Director 51 New Jersey 154-46-2217 Usual Residence of Decedent an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Maryland Caroline Henderson 1 🗌 Yes 2 ဳ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 15287 Westbridge Court 21640 USA should be filed within 72 hours after death and Mental Hygiene.

is marked other than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other tha any injury or other traumatic event, the i phone system installer commercial Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Marinus G. DeRidder, Jr. Joyce E. Corey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1080 Florida Ave.; Bensalem, Pennsylvania 19020 Trudy Lynn Buckalew, sister 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) Beechwood Cemetery Mar 14 2012 Bensalem, Pennsylvania 21. Signature of Juneral Service Licenses 22. Name and Address of FacilityPO Box 160; Greensboro, MD 21639 Fleegle and Helfenbein Funeral Home, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 2/02 CANCER disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): burial-transi that initiated events attending physician and for use as the burial-trar Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ___ in the past 12 months? Month Pregnant at time of death Day Year 2 No 1 Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4. 5 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law perform Yes 2 No 1 🗌 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 XNo 1 Tes Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 KResidence 6 COther (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending ☐ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, within 24 hours after To the Funeral Direc determined City or Town, State) 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 63747 Name and address of person who completed cause of death (Item 23a) (Type, Print) VILLERY 2540 CONTREN Registrar's Signa State Registrar

DHMH 17 Rev 7/2009

510

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Amend #5, 3-20-2012, per FHDR, Certificate of Death 2. Date of Death BEARBORN Physician/ JAMES Thomas March Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard County General Hospital Columbia Howard 7. Age (In yrs. last birthday) ·070≥30×6166 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 🔀 M 2 🗆 F Days Hours Country) 30 6906 72 NY Director Usual Residence of Decedent of Health and Mental Hygiene. i item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2 XNo Ellicott City Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21042 3643 Cragsmoor Court United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Yes 2 No Yes, Give Completed by Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: 3 Widowed 4 Divorced White Year or Dates. 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) FBI <u>Agent</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Lillian Fennell Lancelot Dearborn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s f Health a item 27 Marilynn Alyce Dearborn/Wife 3643 Cragsmoor Court Ellicott City, MD 21042 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)

Ardent Crematory 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot Page 1 ; 1 Burial 2 X Cremation 3 Removal from State 3-19-2012 Hanover, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death SEPTIL Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Abdominal Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury been signed by the attending physician and should be detached for use as the burial-transit · Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Month 2 No 1 Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown After this certificate has been funeral director, page 2 should Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☐ No Hospital Other: 힏 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a 🗗 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KENNETH GEH, AD 36 State Registrar

			Pleas	se Type o lend \$26	r Print in per MD	Black FCHD	k Indeli	ble Ink	. Ens	ure A	All Copie: Mental Hy	s Are	e Leg	jible.		
	-	For State Registrar		Otato	Of Wildingto		Certifica			aria n	-	Reg. No	-21) 2	and the same of th	0445
Physicia	n/	1. Decedent's Name	_	_							2. Date of De Month	Da	ay 0	O12		e of Death
Medic Examin		Evelyn 4a. Facility Name (if		Damaz give street and no			4b. Cit	y, Town, or	Location o	of Death	March	1 40		OIZ of Death		25a [™]
LAGIIIII	C1	5766 Box	Elder	Court					ederi					rede		
Funeral		5. Social Security No		6. Sex	7. Age (In yrs	. last birth	day) If Unc	ler 1 Year s Days	If Under Hours	24 Hrs. Min.	8. Date of Bird (Month, Da				nplace (Star	te or Foreign
Director		025-16-18 Usual Residence of		1 □ M 2 🔀 F	90	Y	rs.				Feb. 2	0,19	922	Mass	sachu	setts
land show	tor	10a. State	10b. County		10c. (City, Town	or Location								10d. Inside	e City Limits
28a-f	Director	Maryland	Frede	rick	Fr	ederi										Yes 2 X No
ith the	ralD	10e. Street and Num					10f. 2	Zip Code						What Cou		
ath w	Funeral	5766 Box	Elder (cedent Ever in I	J.S.	13. Was Dec	217 edent of His	spanic Orio	gin? (Spe	ecify Yes or No-	Un		Stat	tes ican Indian.	
ter de , or its imine	by F	1 Never Marri	ied 2 🗆 Marri	Armed I	Forces?		If Yes, sp	ecify Cubar	n, Mexican	, Puerto	Rićan, etc.)		Bla	ck, White		
ours af tural" al Exa		3 Widowed		If Yes, G Year or								Ш	Specify	. WI	nite	
72 ho n "nat	Completed			t grade complete		(Decedent's Us 'Give kind of w ife. DO NOT u	ork done d		t of work	ing	16b. k	Kind of B	lusiness/l	ndustry	
within giene. er tha		Elementary/Seco	indary (0-12)	College 2	(1-4 or 5+)			acher					E	ducat	tion	
filed all Hyg	o Be	17. Father's Name (F	First, Middle, La	ist)					18. Mothe	er's Nam	e (First, Middle,	Maiden	Surnam	e)		
uld be I Meni marke natic	To	Frank Da									a Cotte					
2 shorth and the and traun		19a. Informant's Na					J				al Route Numbe					E
f Heal f Heal item		Joseph Da 20a. Method of Disp		brotner		. Place of I	Disposition (N	ame of			Jeffers Date				Fown, State	
Page nent o nnt: If iry or		1 🔀 Burial 2 [4 🗌 Donation		3 Removal fro			crematory or Lvet_Ce		1	Marc	h 15,12	Fre	der	ick.N	(arv1	and.
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fur	neral Service Li	eneee///	2011	1					omes P.			1010		
20 E # 9			UL C	10/19	ww		1621	Oposs	umtor	wn P	ike, Fr	<u>ede</u> 1	rick	Mary		
		23a. Part 1. Enter the shock, or hear Immediate Cause (I	rt failure. List or	lu ana sould an	anala lina				, such as	cardiac d	or respiratory an	rest,				mate Between nd Death
Physician/ Medical		disease or conditio resulting in death)	n a	a. Due t	O (or as a cons	ero d	dun	*								
Examiner					Sex o (or as a conse Hype	rter	sin									
_ #	Examiner	Sequentially list con if any, leading to im cause. Enter Under	nmediate 🔝		o (or as a conse											
executed an and rial-transi	Exan	Cause (Disease or i that initiated events resulting in death) L	S	c. Due t	o (or as a conse	equence of):									
E E	_															
ficate g phy as the	Physician/Medica	IE EEMALE:										-				
h certi tendin or use	ian/I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy										of delivery				
e deat the at thed fo	ysic	1 Yes 2 Unknown		4 📙 Pre 9 🔲 Ur	egnant at time o known	of death	5 Other	(specify)					IVIC	Month Day Year		
hat the	by Ph	Part II. Other signif		-	death but not i	resulting in	the underlyin	g cause giv	en in Part	l.	23e. Did to	obacco	use cont	ribute to	the cause of	of death?
uires l in sign	ed b	Chris	nic a	nime							1 🗆	Yes 2	No	3 🗌 Pr	obably 4	Unknown
aw req as bee 2 sho	Completed										24a. Was					gs available of cause of
The la	Con											ormed?		death? 1 Yes	2 N o	
ician: certific rector,	Be	25. Was case referre		Hospital:				Othe	p.		k only one)				2/00	CANA
Phys r this eral di	е: То	1 Yes 2 2 27. Manner of Death		28a. Da	Inpatient 2 te of injury	28b. Tir		DOA 28c. Injury	4 ⊔ Nu		ome 5 X Residence 128d. Describe h				y) / /	yaree .
ath. r: Afte	icat	1 Matural 2 Accident	5 Pending Investiga	ation	onth, Day, Year)	inj	ury M	work'	? Yes 2 🗌	No		ĺ	_			
or Atte fter de irecto n by tl	Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 ∐ Could n determir	28e. Pla	ce of Injury - At ding, etc. (Spec		n, street, facto	ory, office			28f. Location (S			er or Rur	al Route Nu	ımber,
pital o		OG Codifies 1	Vocation in a	Physician: To the	hant of my lend	vuladas d	eath ecourred	et the time	date and	place o	nd due to the er	DUBO(D) :	and man	nor an eta	ıtod	
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the bu	Medical	(Check 2	☐ Medical Ex	aminer: On the b Nurse Practition	asis of examina	tion and/or	investigation, i	n my opinio	n, death oc	courred a	t the time, date a	and place	e, and du	ie to the c	ause(s) and	manner stated.
vithii vithii comp	-	29b. Signature and	title of certifier	dow	- MD.		2	9c. License	number		,	29d. Da	ate signe	d (Month	Day, Year)	
		•		91				NOC	554	63	5 b		3/1	3/	2010	λ
\		Name and address Sued	1111	no completed ca	use of death (It	em 23a) (Ty	teal	ret	Tue.	F	rede	ric	rk.	md	,21	701
Stat Registra	le ar	31. Date filed (Monti	n, Day, Year) MAR 1	6 2012 \$2.	Registrar's Sig	nature A.	park	21								1

Please Type or Print In Black Indelible Ink. Ensure All Copies Are Legible. 12-02107 State of Maryland / Department of Health and Mental Hygiene Teddy Earl Dugan 1. For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day March 13, 2012 1240 hrs **Medical Examiner** Teddy Earl Dugan 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Western Maryland Health System Cumberland Allegany If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number **Funeral** Foreign Country)Maryland Hours Months Days Sept. 5, 1956 Director 218-74-2851 55 1 X M 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 X Yes 2 No Grantsville Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once. Garrett Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21536 116 Durst Court 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Funeral 11 Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces 1 Never Married 2 Married Yes If Yes, Give Year or Dates: White 1 Yes 2 X No specify: 4 X Divorced Specify: 3 Widowed 2 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Baltimore, MD 21215-0036 Tree Trimming Tree Expert 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Freda Crouse Teddy Dugan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 116 Durst Ct., Grantsville, MD Freda E. Quintero/Mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place 1 Burial 2 X Cremation 3 Removal from State Country Side Crematory March 15, 2012 Davidsville, PA 4 Donation 5 Other Specify: 6 22. Name and Address of Facility Newman Funeral Homes, F.A. 21. Signature of Funeral Service Licensee P.O. Box 275, Grantsville, MD 21536 $^{\prime}$ Approximate Interval 23a. Part I, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure List only one cause on each line Death a Complications of Liver Cirrhosis Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examiner cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical UNPENDED AMENDED

igned by the attending physician and be detached for use as the burial - trar Hospital or Attending Physician: The law requires that the death certificate be Box 68760, of Vital Records, P.O. certificate has been sector, page 2 should this After

Division

<u>۾</u>

Completed

29b. Signature and title of certifier

31. Date filed (Month, Pay Year) NAR 16 2012

Ana Rubio MD.

director.

funeral

after death.

Director: /

24 hours after of Funeral Direct

23d. Date of deliver IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Month Day Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Hypertensive Cardiovascular Disease 24b. Were autopsy findings available prior to completion of cause of autopsy performed death? 1 Yes ✓ Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical Other Nursing Home 5 Residence 6 Other: 1 Yes 2 No 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury 27. Manner of Death 1 🗸 Natural 1 Yes 2 No 5 Pending 2 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide 6 Could not be or Town, State) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

DHMH 17 Rev 1/2001 **OCME 2006**

State Registra

ORIGINAL

and manner stated.

Assistant Medical Examiner

2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

29d. Date signed (Month, Day, Year)

March 14, 2012

1	2-0	21	40	
		<i>-</i>	70	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Pernell Lonnie Daw		ns Si For State	ate of Mar	yland /	Departm Certific			and I	Mental Hy		Reg. No	20	12	1041	+
Physician/	_	egistrar . Decedent's Name (First, Midd	le,Last)							2. Date of De				3. Time of Death	
Medical Examine	r	Pernell Lon					0: -			March 1	4, 201	2 c. County of		0723 hrs	_
	4a. Facility Name (if not institution, give street and number) 9211 Stuant Drive						Clinton	n, or Loc	cation of Death		3				
Funeral	5	. Social Security Number	6. Sex	7. Age	e (In yrs. last bi	rthday)	If Under 1		If Under 24Hrs.		Birth (MN	th(MM/DD/YYYY) 9. Birthplace (Si		place (State or	_
Director		579-94-2455	1 X M 2	F	43	Yrs.	Months I	Days	Hours Min.	Nov.	5, 1	.968	Foreign Cour	ntry) DC	
	_	Isual Residence of Decedent			10c. City, Town	or Locatio	200						11	0d. Inside City Limits	s
		0a. State 10b. County			Toc. City, Town	Clinton								1 Yes 2 N	
the Maryland 1 or 28a-f she iffed at socc	5 P	aryland Prince	George	5			10f. Zip Coo	de	CITICO		10g. C	itizen of Wha	at Countr	y?	_
the Ma in or 22 iffied a		9211 Stuart La	ıne			20735						United States			
eath with the Maryland items 23s or 28s-f show ust be notified at once.		1. Marital Status		Decedent d Forces?	Ever in U.S.				nic Origin? (Sp lexican, Puerto		No-	14. Race - White,		an Indian, Black,	
er death with or items 23 coust be no		1 X Never Married 2 Nover Marr	1 Ye	es 2	X No	1	Yes 2X	No s	necify:			Specify:	B1a	ck	
ars after tural"	Ր	15. Decedent's Education (Spe	or Dates:		pleted) 16a	. Decedent	's Usual Occ	upation	(Give kind of v		16b	. Kind of Bus	iness/Inc	dustry	_
5 72 hoi rai Ex	5 -	Elementary/Secondary (0-12)	Colleç	e (1-4 or 5	5+)	during mo			O NOT use reti	rea)			200	20	
5-0036 ed within 72 hour lygiene. other than "natt the Medical Exam Commoleted	-	12th 7. Father's Name (First, Middle	i anti				uner	-	oyed Mother's Name	(First Middle	Maide	en Surname)	no	ne	_
21215-0036 uld be filed within 72 hours after death with the Maryland Markel Hygiers and the Harles 12a or 28a-fahe c event, the Medical Examiner must be notified at occ.		7. Fathers Name (First, Middle	Rothel	Brow	<i>t</i> n			10.	Wottler 5 Name			y Dawk	ins		
Z E B Me Z		9a. Informant's Name/Relation			11	9b. Mailing	Address (S	Street ar	nd Number or F					Zip Code) 20747	7
MD rd 2 shoulth and and 27 is auman	Ł		ucas - S	on	120h Blood		Melro			Distr		Heigh		Maryland_	
Baltimore, permit. Pages I ar Department of Her Important: If ite injury or other tr		20a. Method of Disposition 1 Burial 2 X Crematio	n 3 Remov	al from Sta	ate crema	atory or oth	ner place)		Marc	h 28,					
timent runent ortant:	-	4 Donation 5 Other, € 21. cin u e of Funeral Service					Crema			2012 ewart				Maryland Inc	
Dermi Depa	J.	Jun 1. Sti	ur		M00560	40	01 Ben	nin	g Road	NE Was	hin	gton,	DC	20019	Н
Physician	Ť	23a. Part I. Enter the disease, of failure. List only one cause		at caused	the death. Do	not enter th	ne mode of dy	ying, su	ch as cardiac c	r respiratory a	arrest, s	hock, or hea	rt	Approximate Interva Between Onset and	
/Medical Examiner		Immediate Cause (Final diseas or condition resulting in death)	e a. <mark>Guns</mark> h		ound to	the	neck w	vith	compli	ication	ns		_	Death	_
	1		b.	as a cons	equence of):										
		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	9	as a cons	equence of):										
9		(Disease or injury that initiated events resulting in death) Last	C.	as a cons	equence of):										
			d	222	,27,28a	f no		-027	5_19_1	1.2 cm					
ि इस उ		X UNPENDED			me of pregnanc		т ше, Е	3721	J-10-1		1:	23d. Date of	delivery		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Fuceral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn completely filled in 25 to 15 to 25 t		IF FEMALE: 3b. Was decedent pregnant in past 12 months?	the 1 L	ive birth		_	tal death	3	Ectopic pregna	ancy	l'	Month	Da	ay Year	
lox 687 leath certific e attending;	SICE	1 Yes 2 No 9 U		regnant at Inknown	time of death	5 Ot	her (Specify)								
trithe de ached f		Part II. Other significant cond			h but not result	ing in the u	inderlying cau	use give	en in Part I.	23e, Die	d tobaco			ne cause of death?	
Division of Vital Records, P.O. rat or Attendiog Physician: The law requires that the state death. **I Director: After this certificate has been signed by led in by the funeral director, page 2 should be dease state of the factor of the formal of the factor of the fa	9										Yes 2			ably 4 Unknown	_
ords, wrequii	Completed										topsy	p	rior to ca	opsy findings availab Impletion of cause of	
'Vital Recor hysician: The law r this certificate has b al director, page 2 sh	Ē									1 ✔ Ye	rformed s 2	No 1	eath? Yes	2 No	
certifi certor,		25. Was case referred to medic examiner?	Hospital: 1	7	ent 2 ER/	Outpatient		IO	f Death (Check	only one) ng Home 5	Pasi	idence 6	Other	Scene	_
n of Vi diog Physi . After this funeral di	앍	1 Yes 2 No 27. Manner of Death	28a.	Date of Inju	ury 28t	outpatient Time of I			at Work?			injury occum		-	_
OD C cudiog ath. or: Af			ndina	onth, Day,\ 7—1	1	1 02:2	9 am 1	Yes	s 2 X No	subje	ct s	hot			
Visi	Certification:	3 Suicide 6 Co	uld not be 28e.	Place of Ir	njury - At home,	farm, stre		fice buil	lding, etc.					al Route Number, Cit St. SE	ty
Di spital hours socral		4 X Homicide	termined (Spe		Sidewal					Washi	ngto	n.DC.			_
Division To the Hospital or Attend within 24 hours after death. To the Faueral Director: completely filled in by the i	Medical		Physician: To the caminer: On the b	asis of exa	ny knowledge, d amination and/o	r investiga	tion, in my op	ne, date pinion, d	eand place, and leath occurred	at the time, da	ause(s) ate and	place, and d	ue to the	cause(s)	
5 with	Š.	29b. Signature and title of certi		ner stated.	·		29c. Li	icense r				_		th, Day, Year)	
		Theodore V	u Kin	& J	R. M	. (1)		D.C.M.	.E. 001	WE	M	larch 15,	2012		
	İ	30. Name and address of person Theodore M. King, J			death (Item 23a Nedical Exa		900 W/ B	altimo	ore Street, E	Baltimore	MD 2	1223			
Sta	to				ar's Signature	_		and I I U	Ou 66t, L		.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				
Registra	ar	31. Date filed (Month, Pay Yea	1012 1	wa	1. 0	park									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND #8 PER FH G928 5/27/12 TRT
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 0448 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Physician/ .15 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death MEDICAL NASHINGTON T WASHINGTON PINCE 6EDREE'S 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Year If Under 24 Hrs. 8. Date of Birth If Under 1 9. Birthplace (State or Foreign Country) 5 C **Funeral** 1 □ M 2 🗙 F Months Days Hours Min. Yrs. Director 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director ASHING TON 1 Yes 2 46 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20744 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☑ No Black, White, etc. 1 Never Married 2 Married à Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced BLACK Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ၀ OREGIO 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hunters Mill Ave DIGGS- SPOUSE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 D Burial 2 Cremation 3 Removal from State HETHEL 3-24-12 (EMETERY! ALEXANDRIA 4 Donation 5 Other (Specify) . Signature of Funeral Service Licensee FUNERAL HOME 22. Name and Address of Facility GREENE FRANKLIN ST ALGXANDRIA CC 23a. Part 1. Enter the disease, or combligations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Diseane Onset and Death ORSTAULTUR LU Physician/ CHranice disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of). the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death g Unknown Unknown sate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ¥ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy this certificate Yes within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, it 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **N**O မ 1 Palnpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 🕎 Natural 5 Pending 1 🔲 Yes 2 🗆 No Accident
Suicide
Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1170 Wingshi Rond Fort wast ington mongland. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ RNELIA DAWSON Month 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospice of Chesepeake Annapolis Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours 578-14-7290 Director 1 □ M 2 🔀 F 2/27/1916 Virginia or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director DC None Washington 1 🛣 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20019 USA 5356 E Street S.E. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14 Race - American Indian Armed Forces?
1 ☐ Yes 2 ☐ No Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married 72 hours after Maryland 21215-0036 1 ☐ Yes 2 No Specify: permit. Page 1 and 2 should be filed within 72 hours aft. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exar If Yes, Give Specify: Black 3 XWidowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) $\begin{array}{c} \text{Elementary/Secondary (0-12)} \\ 12\text{th} \end{array}$ College (1-4 or 5+) Own Home Housewife Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Authur Thomas Sarah Randall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Myrna Lois White/Niece 4221 Benning Road NE Washington, DC 20019 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other pl.
Lincoln Memorial 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 03/22/2012 Suitland, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Marshall-March Funeral Home 4308 Suitland Road Suitland, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ a disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed and I-tran that initiated events resulting in death) Last Due to (or as a consequence of) physician a s the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 as the attending IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months

1 Yes 2 No

9 Unknown ģ Month Day Year Pregnant at time of death Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Striknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? has page 2 performed this certificate 2 9 No 1 Yes Yes 2 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 🗌 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DCA □ Hursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28c. Injury at work? 28b. Time of Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After of completely filled in by the funer (Month, Day, Year) 5 Pending 1/Natural 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 💭 estifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 2017 775 30. Name and address of person parien CM37 31. Date filed (Month, Day, Year)

MAR 2 1 2012 State

DHMH 17 Rev 06-2011

Registrar

12-02460 Hayley Doles

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012 10450 1- For State Certificate of Death Registrar Physician/ 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day March 27, 2012 Medical Examiner 0706 hrs HAYLEY FAY DOLES 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Union Hospital Cecil 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State of Right) 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Days 11 Foreign Months 3 Director Hours Country) MARYLAND 473-61-0927 1 M 2 X XF 0 12/16/2011 Usual Residence of Decedent 10a, State 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2XX No MARYLAND CECIL ELKTON with the Maryland 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 227 HOLLINGSWORTH MANOR UNITED STATES 21921 Funeral 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, permit. Pages 1 and 2 should be filed within 72 hours after death 'Opparment of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item injury or other traumatic event, the Medical Examiner must b injury or other traumatic event, the Medical Examiner must b 1 X Never Married 2 Married Armed Forces' If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 2 X No Yes Specify: WHITE If Yes, Give Year or Dates: 4 Divorced 1 Yes 2 No specify: à 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 0 NEVER EMPLOYED NEVER EMPLOYED 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JAMES RANDALL DOLES AMBER BREE ORR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JAMES RANDALL DOLES 227 HOLLINGSWORTH MANOR, ELKTON, MARYLAND 21921 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State NORTH TOTE A STET PURPLITED 1 X Burial 2 Cremation 3 Removal from State MARCH 30, 4 Donation 5 Other Specify METHODIST CEMETERY 2012 NORTH EAST, MARYLAND 21. Signa re ice nsee 22. Name and Address of Facility CROUCH FUNERAL HOME, P.A. SOUTH MAIN STREET, NORTH EAST, MARYLAND2190 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and /Medical Death a. Sudden Unexplained Death In Infancy (SUDI) Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit The law requires that the death certificate be executed Physician/Medical AMENDED 23a, 27, 28a-f, per me, g_{928} 6-29-12 sm the attending physician ed for use as the burial -X UNPENDED Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 235. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy 2 Fetal death Month Dav Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? کَ 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed After this certificate has been s funeral director, page 2 should 24a, Was an 24b. Were autopsy findings available performed? death? Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Other Nursing Home 5 Residence 6 Other: 1 Yes No 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Director: 5 Pending 1 Yes 2 X No unknown 24 hours after death. fd 3-27-12 fd 06:30 am Accident Investigation completely filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. Location (Street and Number or Rural Route Number, City 3 Suicide 6 X Could not be or Town, State) 2 Hollingsworth nor Elkton.MD. within 24 hours at To the Funeral I determined Homicide Single Family Home 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ca 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DOME O.C.M.E. March 28, 2012 30. Name and address of person who completed cause of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 State

DHMH 17 Rev 1/2001 OCME 2006

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician/ Month 3 2:24 Emmons arold 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** University of Social Security Number Baltimore Marylan BALTIMORE If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours **Director** 429-74-2621 84 NOV. 24, ARKANSAS Usual Residence of Decede 28a-f show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits notified at Director 1 Yes 2 No MARYLAND FREDERICK FREDERICK 10e. Street and Numbe 10f. Zip Code ö 10g. Citizen of What Country? must be Funeral items 23a 503 PEARL STREET 21701 U.S.A. death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, 11. Marital Status Examiner Armed Forces?

1 Yes 2 No
If Yes, Give Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ŏ 1 Never Married 2 Married ð Maryland 21215-0036 filed within 72 hours after 1 ☐ Yes 2 B No Specify: "natural" Completed 3 Widowed 4 Divorced WW II Year or Dates WHITE al Hygiene. d other than "natura event, the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 ANIMAL TECH McCLELLAN VETERINARY event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, and Mental h ည DR. AARON EMMONS VIVIAN HALL other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important; If item 27 is any injury or other trau 503 PEARL STREET, FREDERICK, MARYLAND 21701 ANNA MAE EMMONS / WIFE Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) 3/15/2012 FREDERICK, MARYLAND permit. Signature of Funeral Ser 22. Name and Address of Facility ROBERT E. DAILEY & SON F.H., P.A. Sut 2 1201 NORTH MARKET STREET. FREDERICK, MD. 21.701 23a. Part 1. Enter the disease, or comp nplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest one cause on each line. Approximate Interval Between Onset and Death shock, or heart failure. List only Immediate Cause (Final Physician/ Due to (or as a con-equence of): disease or condition Medical resulting in death) Examiner SEVECE Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Physician/Medical **Hospital or Attending Physician:** The law requires that the death certificate be 24 hours after death. Division of Vital Records, P.O. Box 68760 IF FEMALE CERTIFIC yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day 5 Other (specify) Year Pregnant at time of death been signed by the a should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð artens 2 No 1 Tes 3 Probably 4 Unknown corogany Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an hyper lipid cate has ; page 2 : autopsy performed? Yes 2 this certificate 25. Was case referred to medical examiner?
1 ☑ Yes 2 ☐ No completely filled in by the funeral director, 26. Place of Death (Check only one) Be Other: 4 \(\triangle \text{ Nursing Home } 5 \) Residence 6 \(\triangle \text{ Other (Specify)} \) Hospital ျှ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 24 hours after death. Funeral Director: After 5 Pending injury ☐ Natural Accident work? 1 ☐ Yes 2 ☐ No 6/12 Fall stairs Investigation Unknown down 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) PEARL Home FREDERICK Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Contifying Nurse Practitioner 7. The best of my promoted and place and place and due to the cause(s) and manner stated (Check within 2 To the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Dav. Year)

Registrar
DHMH 17 Rev 06-201:

State

South Greene St. Baltimoro, MD alad

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Pe

gistrar's Signature

Month Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 16, Day 2012 Year Physician/ John Eyler Henry 0605 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Kline Hospice House Mt. Airy Social Security Numbe If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 214-28-2439 86 **Director** XXM 2 🗆 F Sept 21, 1925 Maryland or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Frederick Frederick Maryland XX Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö er than "natural", or items 23a or the Medical Examiner must be Funeral USA 914 Walnut Street 21701 within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2XXNo Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 white 1 Yes 2XXNo Specify. If Yes, Give Completed 3 ▼ Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Page 1 and 2 should be filled within 7 Department of Heath and Mental Hygiens Important: If item 27 is marked other than any injury or other traumatic mans injury or other traumatic mans injury or other traumatic Elementary/Secondary (0-12) College (1-4 or 5+) Vending machines owner/operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Vergie Smith Harry Eyler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21798 Mary Filler - sister 10 Rosewood Court, Woodsboro, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Resthaven Memorial 3-19-2012 Frederick, Maryland ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stauffer Funeral Home ignature of Funeral Service Licenses 21702 1621 Opossumtown Pike, Frederick, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition a consequence of): Medical resulting in death) Due to (or a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): burial-transit Cause (Disease or Injury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year signed by the at a be detached for signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Diabetes Division of Vital Records, 1 ☐ Yes 2 Z No 3 ☐ Probably 4 ☐ Unknown Completed this certificate has been siral director, page 2 should 24b. Were autopsy findings available typortension 24a. Was an prior to completion of cause of death?

1 Yes 2 No to the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate completely filled in water. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 \square Yes Other: 4 Nursing Home 5 Residence P 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 1 Natural 5 Pending work?
1 Yes 2 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar 3 🗌

 \sim

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

540,5

only one) 29b. Signaturaand title of certifier

-m

74

Registrar's Signature

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

Frederick mo 21702

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MARCH 15,2012 Physician/ BERNARDO VICENTE ESCOTO-FLORES 12:40P M Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min. 1 M 2 F $J_{u}^{Month, Day}$, 1930 Cuba 81 **Director** 164-44-5308 Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at rector Frederick 1 Yes 2 No Maryland Frederick Ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21701 6101 Brookhaven Drive 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No 1 Never Married 2 X Married þ Maryland 21215-0036 1 XYes 2 □ No Specify: Cuban If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Finance Banker other traumatic event, Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ္ဝ Ofelia Flores Manuel Escoto permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6101 Brookhaven Drive, Frederick, MD 21701 Ofelia M. Escoto / Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State March 16, cemetery, crematory or other place) 1 Burial 2 K Cremation 3 Removal from State 4 Donation 5 Other (Specify) Resthaven Crematory 2012 Frederick, Maryland 21. Signatur S F ral S rvice Licensee Resthaven Funeral Services, Skkot Cody P.A. Frederick, MD 21701 9501 Catoctin Mountain Hwy. or complications that caused the death. Do not enter the mode of dying, such as or respiratory arrest, List only one cause on even line. 23a. Part 1. Enter the disease shock, or beart failure. Li Immediate Cause (Fina disease or condition resulting in death) Approximate Interval Between Onset and Death Physician Medical resulting in death) Due to (or **Examiner** Sequentially list conditions if any, leaving to immediate cause. Enter Underlying Examir burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last and physician Physician/Medical that the death certificate be Box 68760 as the l attending asn 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No jo Month Other (specify) Pregnant at time of death signed by the at d be detached fo 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobaccourse contribute to the cause of death? by 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform ed? 1 Yes 2 No certificate No Yes 2 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific 25. Was case referred to -dical 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 1 No 0 1 🗌 Yes Inpatient 2 ER/Outpatient 3 DOA 27. Mann Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred iniurv 5 Pending Natural ☐ Accident Investigation filled in by the 6 Could not be Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier сотріете Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature ar title of certifie ianed (Mor Item 23a) (Type, Print person who gompl

State Registrar Day, Year

MAR

32.

Redistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Elliott Gloria L. 03/13/2012 6.42P Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Hospital Cheverly Prince George If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 08/14/1935 Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday **Funeral Director** 577-50-5668 1 🗆 M 2 🕱 F 76 SC Usual Residence of Decedent ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Washington, DC 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral within 72 hours after death with 20019 US 3981 Blaine Street NE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. δ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: Black 3 X Widowed 4 Divorced Completed Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) DC Public Schools Book Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ pe 1 Mabel Kay Roosevelt Thorton permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) B972 Ames St NE Washington, DC 20019 Kim Elliott daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Cemetery 03/21/2012 Suitland, MD Signature of Funeral Se 22. Name and Address of Facility Freeman Funeral Services Temple Hills, MD 20748 4594 Beech 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory are shock, or heart failure. List only one cause on each line. Approximate Rerval Between Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of resulting in death) Last Physician/Medical death certificate be IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes Certificate: To Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred iniury Natural 5 Pending 2 Accident Investigation 24 hours after deat Funeral Director: 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of oe 29c. License number 29d. Date signed Month. Day 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LAMES CARVLINGS 3001 (+US)

Registrar

Box 68760

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 11:50 PM Vernon Phillip Evans, Sr. Marc Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c County of Death Regiona Ldurel Hospita Prince George aure Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1 ▼ M 2 □ F Months Days Min. 217-42-2579 67 **Director** 09/11/1944 Wash. Usual Residence of Decedent or 28a-f show 10a. State with the Maryland must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Md. P.G. Lanham 1 Yes 2 No 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral "natural", or items 23a 3210 Reed Street # 2632 20706 U.S.A. death \ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Examiner Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 🔀 No Yes, Give Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2X No Specify: Black Completed 3 XWidowed 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72 l h and Mental Hygiene. **7 is marked other than "r** MidSouth Elementary/Seconday (0-12) College (1-4 or 5+) Cabinet Makers Cabinet Maker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Ozelle Pixley Noble Evans 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Page 1 and 2 st ment of Health a tant: If item 27 is Robyn M. Evans/Daughter 3210 Reed Street # 2632, Lanham, Maryland 20706 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of F
Important: If ite
any injury or ott 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 🙀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory, Inc. 03/19/12 Beltsville,Md. Signature of Funeral Service Licenses Name and Address of Facility
Henry S. Washington & Sons Co., Inc. au Abl CC0316 4925 Burroughs Ave., N.E., Washington, D.C. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ neumonia disease or condition resulting in death) Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Exami and tran Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Pregnant at time of death Day Year 2 No ed by the detached 9 Unknown 9 Unknown P.O. I been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Stage Renal Disease Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform performed? Yes 2 No certificate Division of Vital 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospita 2 X No 1 Tes Other: ျှ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending nours after death.

neral Director; Affilled in by the fur 1 Yes Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital of within 24 hours a To the Funeral D completed filled is Medical 29a. Certifier Kertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) aurel Regional Hospita 7300 aritha Gorant 20707 Ldurel 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last, 2 Date of Death 3. Time of Death Physician/ 17 Day 2012 Year EINSPRUCH MARIE MAR. 8:05 PM Medical 4a. Facility Name (if not institution, give street and num **Examiner** 4c. County of Death
MONTGOMERY VILLAGE AT ROCKVILLE ROCKVILLE Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 7. Age (In yrs. last birthday) (Month, Day, YAPR. 3 Days Hours Min 212-50-1472 1 □ M 2**X** F 103 1909 PENNSYLVANIA Director APR. Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10a, State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MONTGOMERY ROCKVILLE MD. 1 Yes 2 □ No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 20850 Funeral 9701 VEIRS DRIVE 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🌠 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: WHITE Completed 3 XWidowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) RELIGION MISSIONARY Be 18. Mother's Name (First, Middle, Maiden Surname)
ANNA KEMMERER 17. Father's Name (First, Middle, Last) ဂ္ **GERLACH** ED WIN В. 19a. Informant's Name/Relationship (Type, Print) 19b Mailing Address (Street and Number or Rural Route Number City or Town State, Zin Cade) 9701 VEIRS DR., ROCKVILLE, MD. 20850 FRANK McGOVERN- EXECUTOR 20b. Place of Disposition (Name of cemetery, crematory or other place)
PARKWOOD CEM. 20a. Method of Disposition 20c. Location - City or Town, State Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 3/26/2012 BALTIMORE, MD. 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility 2222-WISCONSIN AVE., NW HYSONG CO., INC. 20 WASHINGTON, DC 20007 CCo367 23a. Part 1. Enter the disease, or complications had caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician/ PNEUMONIE Medical Due to (or as a consequence of) **Examiner** FSTIRATORY FAILUR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that be the cause of the c Examine Due to (or as a consequence of) To the Hospital or Attending Physician; The law requires that the death certificate be executed burial-transi that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☒ No ate has been signed by the atte page 2 should be detached for Day Month Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown . Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 2 🗌 No Yes Be 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) examiner? 2 No ျပ 4 Aursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending work after death. 2 No 1 Yes 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Pranticiners to the best of my knowledg within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00057158 MARCH 18 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar PRIVE

ROCKULLE

Mn 20850

9701

Au No m

VEIRS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mar 26, 2012 0005 Leonard Evans Paul Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Allegany Cumberland Golden Living Center If Under 1 Year If Under 24 Hrs Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) MD 1 □ M 2 □ F Hours Min Sep 8. **Director** 218-12-5273 86 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27.5 is marked outher than "natural", or items 23a or 28a-f sho ury or or other traumatic event, the Medical Examiner must be notified at ury or or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Cumberland Allegany 1 Xes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21502 USA 512 Winifred Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: 3 XVidowed 4 Divorced WWII white Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Kelly Springfield Tire Co. tire builder Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မှ Jennie Anderson John Evans 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 228 Hite Hollow Road Hyndman PA 228 Hite Hollow Road 15545 Pam Shaffer daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State rostburg Memorial Park XBurial 2 Cremation 3 Removal from State Important: I any injury o 3/29/2012 MD Frostburg 4 ☐ Donation 5 ☐ Other (Specify) Ignatu of Funeral Service Licensee 22. Name and Address of Facility
Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the milde of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final hscase Physician/ disease or condition resulting in death) Medical Due to (or as a conseque of) Examiner Sequentially list conditions, If any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated exects Due to (or as a nonsequence of) Exami or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) ☐ Pregnam ☐ Unknown Yes Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Nunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 2 🗌 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 1 🗌 Yes 2 X No 4 Sursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 5 Pending work? Natural 2 🗆 No Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital o within 24 hours af To the Funeral Di Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 1)0033280 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ave. Ste. 101 umberland 31. Date filed (Month, Day, Year) APR 0 4 2012 32. Registrar Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MARCH $20\overset{\text{par}}{12}$ 3:01 P M KAREN LEE FORNEY Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK Social Security Number If Under 1 Year If Under 24 Hrs. . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Year) 1964 1 🗆 M 2 🕱 F July 20 Days Hours **Director** 47 Pennsylvania 216-90-3116 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at ld be filed within 72 hours after death with the Maryland Mental Hygiene. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No Maryland Thurmont Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 37 Frederick Road 21788 United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🖾 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Yes Give 1 ☐ Yes 2 🛛 No Specify: 3 Widowed 4 Divorced Specify: Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental James Danner Doris Whipp permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Larry Forney / Husband Frederick Road, Thurmont, Maryland 21788 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗆 Burial 2 🗵 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Crematory Inc.3/20/2012 Frederick, Maryland. 22. Name and Address of Facility
Stauffer Funeral Homes P. A.
1621 Opossumtown Pike, Frederick, Maryland 21702 21. Signature of Ineral Servi L cer Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between PROBABLE HONTE MYOCARDIAL Immediate Cause (Final Onset and Death Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine rany, reading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (of as a consequence on To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☑ No Pregnant at time of death Month Day Year 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ MORBU OBESITY Records, 1 Yes 2 No 3 Probably 4 Unknown Be Completed CHRONIC IRON DEFICIENCY ANEMIA 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? HYPERLIPIDEMIA 2 No _J Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Nes 2 No nours after death.

neral Director: After this of filled in by the funeral directors. Certificate: To Other: 1 ☐ Inpatient 2 M ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation
Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours Funeral Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed (Check within 2 3[Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year) 2012 00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 义 BRAD J. COOPER m.D. 52 WATER THURMONT, MD. 21798 31 Date filed (Month Registrar's Signature State

Registrar

B

23d. Date of delivery Month Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) ess of person who completed cause of death (Item 23a) (Type, Print) SOUNGOALE AUE FEBRASSUES, MT MD321 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 09 Registrar **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2:15

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 ☐ Yes 2 XNo

Maryland

White

 P^{M}

DHMH 17 Rev 1/2001

Physician/

Baltimore, Maryland 21215-0036

certificate To the Hospital or Attending Physician; within 24 hours after death. within 2 To the I comple

Division of Vital Records, P.O. Box 68760

edical Examin	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequence of): d.			
nysician/int	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pi 4 Pregnant at time of death 5 Other (spe		23d. Date of delivery Month Di	
ted by P		ontributing to death but not resulting in the underlying co	ause given in Part I.	23e. Did tobacco use contribute to the	
Comple				24a. Was an autopsy prior to comperformed? 1 Yes 2 No 1 Yes 2	eletion of cause of
e e	25. Was case referred to medical examiner?		26. Place of Death (Check only	one)	
0	1 ☐ Yes 2 ☐ No	Hospital: 1 \square Inpatient 2 \square ER/Outpatient 3 \square DO.	Other: 4 Nursing Home	5 Residence 6 Other (Specify)	
ricate:	27. Manner Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not b	(Month, Day, Year) injury M	3c. Injury at work? 1 Yes 2 No	Describe how injury occurred	
al Cerri	4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, building, etc. (Specify)		ocation (Street and Number or Rural Ro City or Town, State)	oute Number,
Medic	(Check 2 ☐ Medical Exami only one) 3 ☐ Certifying Nurs	sician: To the best of my knowledge, death occurred at ner: On the basis of examination and/or investigation, in me Practitioner: To the best of my knowledge, death occur	ny opinion, death occurred at the t	me, date and place, and due to the cause	(s) and manner stated.
	29h Signature and title of certifier	200	Linanna numbar	00:1 D-1-1 1 04 11 D-	14 - 1

20.12

CAMBRIDGE MD 26613

DHMH 17 Rev 06-2011

State Registrar 503

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HAWW4

NOMAN

31. Date filed (Month

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) Month **Physician** Rubert Fera /Medical 4b. City, Town, or Locetion of Deeth 4a Fecility Neme (If not Institution, give street end number) 4c. County of Death Examiner workersville V My Canti FREQUEULI Glade If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Yeer) 7. Age (In yrs. lest birthday) 5. Social Security Number **Funeral** Days Hours Months 1 M 2 □ F Director May 30 1918 213-18-8274 Pennsylvania 93 Usual Residence of Decedent the Marylend 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 7 is marked other than "naturel", or frems 23s or 28s-f show traumatic event, the Medical Exactiner must be notified at 1. Yes 2 □ No **Funeral Director** Maryland Frederick Thurmont 10g. Citizen of What Country? 10f. Zip Code 10e. Street end Number Peges 1 and 2 should be filed within 72 hours effer death with nent of Health end Mantal Hygiene. Int: If Item 27 is marked other than "naturel, or items 23e or 21788 U.S.A. 213 West Main Street 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Merital Status 1 May Yes 2 □ No If Yes, Give Year or Dates: WW II 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 Mo Specify: Specify: Completed by 3 Widowed 4 Divorced White 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Trackman Rail Road 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Be Zacharias Ford Mary McDaniel 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health er important: If item 27 is any injury or other trau / Daughter 12820 Old Frederick Rd., Rocky Ridge, MD., 21778 Nancy Seiss 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 □ Cremation 3 □ Removal from State 3/17/12 Thurmont, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Blue Ridge Cemetery 21. Signal of Pineral Servi 22. Name and Address of Facility Robert E. Dailey & Son F.H., P.A. 615 East Main Street, Thurmont, Maryland 21788 23a. Part I. Enter the disease, or complication for the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) MENETHS /Medical Examiner Physician/Medical Examiner nding physiclan and usa as the buriel-transit or Attending Physician: The lew requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of) Division of Vital Records, P.O. Box 68760, by the attending physiclan ached for usa as the burie Due to (or as e consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditione contributing to death but not resulting in the underlying cause given in Part I. 1 Yee 2 No 3 Probabty 4 Unknown certificeta has been signed b irector, paga 2 should be detr Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 □ No ours efter death.

eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2X No Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation 1 Naturel 1 ☐ Yes 2 ☐ No 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital of within 24 hours of To the Funeral D Certifying Physicien: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated.

Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signat 29c. License number d title of certifier D0062223 dress of person who completed cause of death (Item 23a) (Type, Print)

EN BELANUM, TO 1967 JORIUE, PECARNICE MD 21262 MAYEEM 31. Dete filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 Month 42 AM Ola Friend March Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Memorial Garrett Co. Hospital Oakland Garrett Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral 9. Birthplace (State or Foreign 1 □ M 2 🛭 F Months Days Hours Maryland Yrs. Director 220-34-1560 84 Usual Residence of Decedent show 10a. State 10b County 10c. City. Town or Location Examiner must be notified at 10d. Inside City Limits Director 28a-f 1 X Yes 2 No MD Garrett Loch Lynn 10e. Street and Number ò 10f. Zip Code 10g, Citizen of What Country? Funeral with 1 23a 121 East 1st Ave. 21550 U.S.A items ? 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? 1 Yes 2 XNo Black, White, etc. 1 Never Married 2 Married "natural", or Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes. Give 3X Widowed 4 □ Divorced Specify. Year or Dates White and Mental Hygiene. is marked other than "natur aumatic event, the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10 Nurse's Aide Nursing Home Be permit. Page 1 and 2 should be filed v Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည George David Blizzard Lilly Victoria Sims 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Bernard/ Daughter 2180 Pleasant Valley RD., Oakland MD 21550 20a. Method of Disposition 20c. Location - City or Town, State 20b Place of Disposition (Name of Garhern Cremeton Option July) Date 1 X Burial 2 Cremation 3 Removal from State Memorial Gardens 3/15/12 4 Donation 5 Other (Specify) Oakland, Maryland 21. Signature of Suneral Service Ligensee 22. Name and Address of Facility Newman Funeral Homes P.A. Second St., Oakland, MD 21550 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Winonio disease or condition resulting in death) uc Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate Cause (Disease or linjury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as the attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? for Month Day Year Pregnant at time of death ed by the a Unknown Unknown as been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy completed filled in by the funeral director, page 2 certificate ! 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify, 2-No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 Yes 2 No 1 Natural 5 Pending iniury 24 hours after death. Funeral Director: A Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined

within 2 To the

State Registrar

Medical

29a. Certifier

(Check

only one) 29b. Signature and title of certific

Thomas

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

311

Johnson MD

MAR 1 5 2012

1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

N Fourth St., Oakland,

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

153

City or Town, State)

MD 21550

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death March 14, Day 2012 Year Physician/ 2:05 Elaine Edith Grant A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Caroline Denton Caroline Hospice Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min January 2, Maine **Director** 006-40-5113 70 Usual Residence of Decedent show ms 23a or 28a-f shor must be notified at 10b. County 10c. City, Town or Location with the Maryland 10a. State 10d. Inside City Limits Director 1 🗌 Yes 2 💢 No Maryland Cordova Talbot 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21625 USA 31060 Skipton Cordova Road items 2 be filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, the Medical Examiner Armed Forces?

1 Yes 2 X No Black, White, etc ò 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: "natural", Completed 3 - Widowed 4 X Divorced White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. 12 H.S. Grad. College (1-4 or 5+) Director Nonprofit of Health and Mental Hygie If item 27 is marked other or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Ralph Tozier Grant, Sr. Norma Elaine Mitchell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Annapolis, Maryland 21409 Heather Applefeld/daughter 1392 Almond Drive Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or oth Date cemetery, crematory or other place) 1 🔲 Burial 2 💢 Cremation 3 🗆 Removal from State Capitol Crematory March 14,2012 Dover, Delaware 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ucentee Moore Funeral Home, P.A. 22. Name and Address of Facility Denton, Maryland 21629 12 South Second Street 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ 5 9 disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical b Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.
b Funeral Director: After this certificate has been signed by the attending physicial P.O. Box 68760 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death been signed by the s should be detached t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOS ton 1 ☐ Yes 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Accident Suici-1 Natural 5 Pending Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical 29a, Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the I within 2.

State Registrar 3 🗆

Dr. Lakshmi Vaidyanathan

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

219

Registrar's Signal re

29b. Signature and title of certifier

Lable

only one)

31. Date filed (Mor

DHMH 17 Rev 7/2009

S. Washington St

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

29d. Date signed (Month, Day, Year)

2/60

March

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ March 9, 2012 11:10 A M Martha Jane Goehringer Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Goodwill Mennonite Home Grantsville Garrett . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** Month, Day Ye 1 🗆 M 2 🛣 F Days Hours Months 1919 Maryland 220-10-0415 92 Director Auq. Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 X Yes 2 No MD Accident Garrett 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 101 Town View Dr., Apt. 5 21520 USA ural", or items 2 Examiner mus death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Yes 2 No Yes, Give ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 filed within 72 hours after 1 ☐ Yes 2 K No Specify: "natural", Completed Specify: White 3 Widowed 4 Divorced Year or Dates. Medical Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) id Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) of Health and Mental Hygiene. item 27 is marked other that other traumatic event, the I Ŕ Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Page 1 and 2 should be Leslie Rodeheaver Grace Savage 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kimberly A. DuVal/Daughter 30 Fishback Ct., Warrenton, VA 20186 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of F Important: If ite any injury or otl ☐ Burial 2 K Cremation 3 ☐ Removal from State Country Side Crematory March 11, 2012 Davidsville, PA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Newman Funeral Homes, P.A. 21. Signature of Funeral Service Licensee P.O. Box 275, Grantsville, MD 23a. Part 1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cau Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Se uentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician I for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Year Pregnant at time of death Month Dav ned by the a detached for signed by the 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy perform this certificate 1 ☐ Yes 2 ☐ No Yes or Attending Physician: filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After to completed filled in by the funera 5 Pending work 1 🗌 Yes 2 🗌 No Investigation Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check

State Registrar 29b. Signature

Robin Bissell, 124 Miller St., Grantsville, MD 31. Date filed (Month, Day, 32. Registrar's Signature 5 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

within 2

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

0034231

21536

29d. Date signed (Month, Day, Year)

March 9, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			_ (0)	State of Ma	aryland				and M	ental Hy	giene		
			State Registrar			Cer	tificate of L	Death			Reg. No. 2] [2	10465
	Physicia	n/	1. Decedent's Name (First, Middle, Last)							Date of Dea Month	h 8 ^{Day} 201	Year	3. Time of Death 3:15 P M
٠.	Medic	al	Elaine 4a. Facility Name (if not institution, give str	H. Gord	on					Marc			
	Examin	er	Larkin Chase Rehab	,	n Cont	tor	4b. City, Town, o	r Location of Bow			4c. County		eorge's
• 10	Funeral	2	5. Social Security Number 6. Sex		e (In yrs. last		If Under 1 Year	If Under 2		8. Date of Birt			nplace (State or Foreign
	Director		577-36-0856 1 🗆	M 2 🖰 F	85	Yrs.	Months Days	Hours	Min.	(Month, Day		Cou	
	T 00 H		Usual Residence of Decedent 10a, State 10b, County							March	16,1926		
	ryland -f sh	cto			10c. City, T	lown or Loc	ation	a	4 1				10d. Inside City Limits 1 Yes 2 □ No
	e Ma r 28a notifi	Director	Maryland Prince Geo	rge's			10f. Zip Code	Capit	OT H	leights T	40 00	M/h - 4 O	
	vith th						1 '	0743			10g. Citizen of		States
	ems r mu	Funeral	4202 Alton Street 11. Marital Status	2. Was Decedent E	ver in U.S.	13. V	Vas Decedent of H Yes, specify Cuba		in? (Spec	cify Yes or No-			ican Indian,
Q	ter de or it	by F	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🔀	No				, Puerto R	Rican, etc.)	Bla	ck, White,	etc.
9	urs af ural" al Exa	ted	3 Nidowed 4 Divorced	If Yes, Give Year or Dates.		1	☐ Yes 2 🔼 No	Specify:			Specify	Amer	ican
2	within 72 hours after death with the Maryland glene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at the Medical Examiner must be notified at	Completed	15. Decedent's Educ (Specify only highest grade		1	(Give k	ent's Usual Occup ind of work done o		of workin	g	16b. Kind of B		
72	ithin 7 ene. • than he M	Son	Elementary/Secondary (0-12)	College (1-4 or 5	i+)	life. DO	NOT use retired) Nursir	10			F	riva	ite
0	교수급별	Be (17. Father's Name (First, Middle, Last)				Nulbil		r's Name	(First. Middle.	Maiden Surnam	e)	
Maryland 21215-0036	Q E 2 0	10	Willi	e Harris						11a Hai		,	
ary	should and Me is mar raumati		19a. Informant's Name/Relationship (Type	, Print)		19b. Mailin	g Address (Street	and Number	r or Rural	Route Number	r, City or Town, S	State, Zip	Code)
Σ	and 2 s Health em 27 ther tra		Pamela Mimms - Dau	ghter		6351	Lewis Av	enue	Lon	g Beacl	n, CA	0805	
ore	t of Healt If item 2 or other		20a. Method of Disposition 1 → Burial 2 → Cremation 3 → Re	emoval from State	20b. Plac cem	ce of Dispos netery, crem	sition (Name of natory or other plac	e) Ma	$\operatorname{arch}^{^{\mathrm{D}i}}$	ate 9,	20c. Location	- City or T	own, State
Ē	t. Page tment c tant: If jury or		4 ☐ Donation 5 ☐ Other (Specify)			Harm			2	2012			Maryland
Baltimore,	permit. Page 1 a Department of H Important: If ite any injury or ott		21. Signature of Funeral Service Lin nsee	124	0560		Name and Addre						
			23a. Part 1. Enter the disease, or complice		0560		001 Benni					DC	20019 Approximate
			shock, or heart failure. List only one of the shock is the shock in the shock is the shock in th	cause on each line).	JO HOT OILO	tillo illodo or dylli	9, 00011 00 0	our draw or	roopiratory arr	oot,		Interval Between Onset and Death
	Physician/ Medical		disease or condition resulting in death)	Deme Due to (or as a	entia	ice of:						-	
P	Examiner			200 10 (0) 000									
		Examiner	Sequentially list conditions, b. if any, leading to immediate cause. Enter Underlying	Due to (or as a	a consequen	ce of):							
	cuted nd transi	kam	Cause (Disease or injury that initiated events c.										
	e exe		resulting in death) Last	Due to (or as a	a consequen	ice of):							
3	certificate be executed nding physician and use as the burial-transit	edical	d.									-	
200	ding	Ň	IF FEMALE: 23b. Was decedent pregnant 23c	c. If yes, outcome	of pregnancy	y					and De	an of dati	
. Box 68	atten atten I for u	ciar	in the past 12 months?		2 Fetal d	eath 3 🗌	Ectopic pregnand Other (specify)	Çy				ite of deliv onth	Day Year
B	the de by the achec	hysi	9 Unknown	9 🗌 Unknown									
J.	that med b	Completed by Physician/M	Part II. Other significant conditions control	ributing to death be	ut not resulti	ing in the u	nderlying cause giv	ven in Part I.		23e. Did to	bacco use cont	ribute to t	the cause of death?
Division of Vital Records,	quires en sig ould b	peq	General Debility							1 🗆 '	res 2 No	3 🗆 Pro	obably 4 🗆 Unknown
00	aw re as be	ıple								24a. Was a	sv	prior to co	opsy findings available ompletion of cause of
Y	The late h	Con								perfo 1 \(\sum \) Yes		death? 1 🗌 Yes	2 🗆 No
ta	ician: sertific ector	Be	25. Was case referred to medical examiner?	spital:				ace of Death					
>	Phys this ral dii	<u>1</u>	1 ☐ Yes 2 ☑ No ☐ ☐ ☐ 27. Manner of Death	1 Inpatie	ent 2 ER	Outpatien b. Time of	DOA Othe	4 🗀 Nur			lence 6 Oth		y)
o O	ding th. : After e fune	Certificate:	1 Natural 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Day		injury	work	γαι ? Yes 2 □ I		6a. Describe fi	ow injury occurr	ea	
1210	Atter er dea ector by the	ırtifi	3 Suicide 6 Could not be	28e. Place of Inju	ry - At home	e, farm, stre			-			er or Rura	al Route Number,
2	tal or rs after al Dir		/	building, etc	:. (Specify)				-	City or Tow	n, State)		
	Hospi 4 hou uner	Medical	29a. Certifier 1 Certifying Physicia (Check 2 Medical Examiner	an: To the best of a	my knowledg	ge, death o	ccurred at the time	e, date and p	place, and	d due to the ca	use(s) and man	ner as stat	ted.
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Me	only one) 3 Certifying Nurse F 29b. Signature and title of certifier	Practitioner: To the	e best of my l	knowledge,	death occurred at t	he time, date	e and plac	e, and due to the	ne cause(s) and r	nanner as	stated.
-	7 × 7 × 00		W/L	a'				5217			29d. Date signe March		
	3		30. Name and address of person who com	pleted cause of de	eath (Item 23	Ba) (Type, P		J411			rial CII	10,	2012
	O.			Greenbel				Co11	ege 1	Park, M	laryland	. 20	740
	Stat		31. Date filed (Month, Day, Year)	32. Registra	r's Signature	1							
	Registra	ir	MAR - DAVIE LAND	W 1. 1	A area								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2012 Physician/ Grace Ρ. 10:58 A M Greger March 18, Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 3317 Wake Drive Kensington Montgomery Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 297-24-7528 81 **Director** 1 M 2 X XF 12/07/1930 Missouri Usual Residence of Decede r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2XX No Maryland Montgomery Kensington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3317 Wake Drive 20895 11. Marital Status Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2XX Married 1 ☐ Yes 2xx No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2x No Specify. Specify. White Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Broker Real Estate other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F မ Joseph J. Doy1e Harriet Seaman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) e 1 and 2 stoof Health a Department of Health a Important: If item 27 is any injury or other tra once. 15091 Wetherburn Dr. Centreville, VA Polly Herpy / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 🗷 Buria, 2 🗆 Cremation 3 🗆 Removal from State Silver Spring, MD 4 ☐ Doration 5 ☐ Other (Specify) 03/22/2012 | Of Heaven Cem. 22. Name and Address of Facilit George P. Kalas Funeral Home PA 21. Signature of Funeral Service Licensee 6160 Oxon Hill Rd. Oxon Hill, Maryland 20745 23a. Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 16 disease or condition resulting in death) 168,0 Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Day Pregnant at time of death 1 Yes 2 2 Unknown 9 Unknown Part II. <mark>Other significant condition</mark>s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No ☐ Yes 2xxNo To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, completely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 1 X Natural 5 Pending ☐ Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death account at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: 1 the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License number 24 Hankesbury (ver spring mi D00478 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mo om E

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 06-2011

State Registrar Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland	d / Depa	artment of Heal	Ith and M	ental Hyg	iene	10	10167
	_		State Registrar	Cer	tificate of Dea	th	R	eg. No. 2	112	1046/
	Physicia	n/	1. Decedent's Name (First, Middle, Last)				Date of Death Month	h Day	Year	3. Time of Death
	Medic	al	Helen Marie Hubley				March 2	1, 2012	2	10:50 p.M.
	Examin	er	4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Loca	tion of Death		4c. County		
	Funeral		45333 Barefoot Drive 5. Social Security Number 6. Sex 7. Age (In yrs. la.	st hirthday)	California If Under 1 Year If U	Inder 24 Hrs.	8. Date of Birth	St. M	_	ace (State or Foreign
	Director-		032-14-5538 1□M2\\ F	Yrs.	Months Days Hou	urs Min.	(Month, Day,		Counti	ry)
	- MC		Usual Residence of Decedent 85				05/07/19	926		chusetts
	yland f shc ed at	ctor	10a. State 10b. County 10c. City.	, Town or Loc	cation				10	Dd. Inside City Limits
	r 28a)ire	Maryland St. Mary's Cali	fornia						1 Yes 2 X No
	ith th	ra l			10f. Zip Code			0g. Citizen of		
	ath w	Funeral Director	45333 Barefoot Drive 11. Marital Status 12. Was Decedent Ever in U.S.	13. V	20619 Vas Decedent of Hispania	ic Origin? (Spec		Jnited	e - America	
9	or ite	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No	lf	f Yes, specify Cuban, Me	xican, Puerto F	Rican, etc.)		ck, White, e	
93	ırs aff ural", IExa	ed	3 X Widowed 4 ☐ Divorced If Yes, Give Year or Dates.	1	Yes 2 XNo Spe	ecify:		Specify	White	2
5-	2 hou "nati	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	lent's Usual Occupation kind of work done during	most of workin	ıq İ	16b. Kind of B	usiness/Ind	ustry
12	thin 7 sne. than the Mo	S m	Elementary/Secondary (0-12) College (1-4 or 5+)		O NOT use retired)			7-11		
d 2	ed wi Hygie other ent, tl	a)	12 17. Father's Name (First, Middle, Last)	Purcha	asing Agent	Mother's Name	(First, Middle, M	College Jaiden Surnami		
lan	be fill ental rked or ic evo	မ	William Devery			ances C		algeri opinari	-/	
ary	hould ind M s mai		19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street and No			City or Town, S	State, Zip Co	ode)
Σ	id 2 sealth an 27 i		Kenneth Hubley/Son	45333	Barefoot I	Drive,	Califor	nia, MD	206	19
ore	of He of He of iten of oth		20a. Method of Disposition 20b. Pl. 1 XBurial 2 Cremation 3 Removal from State	ace of Dispor	sition (Name of natory or other place)	D	ate	20c. Location	- City or Tov	vn, State
Ē	. Pag ment tant: jury o			ell Gr	ove Cemeter	y 03/31	/2012 1	Framing	ham,	MA
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any fijury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Ucansee		. Name and Address of F	DLT	nsfield			e, P.A.
			Danielle Ward M01403		2955 Hollywo					20650
	i Secondario		23a. Part 1. Enter the disease, or complications the caused the death shock, or heart failure. List only one cause or each liminate cause (Final	. Do not ente	er the mode of dying, suc	on as cardiac or	respiratory arre	SI,		Approximate Interval Between Onset and Death
	Physician Medical		disease or condition	Ca	ncer					
ومسا	Examiner		Due to (or as a conseque	ence oi):						
		ner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of the conditions).	ence of):						
	uted d ansit	ami	cause. Enter Underlying Cause (Disease or injury that initiated events c.							
	exec an an ırial-tı	dical Examiner	resulting in death) Last Due to (or as a consequence)	ence of):						
9	ate be executed bhysician and the burial-transit	dica	d							
587	eath certificat attending ph		IF FEMALE: 23c. If yes, outcome of pregnant	nev						
Box 687	ath ce attend for us	cian	in the past 12 months?	Ideath 3 🗌	Ectopic pregnancy Other (specify)				te of deliver onth	ry Day Year
m	the de	ysi	1 Yes 2 No 4 Pregnant at time of de g Unknown	Cutil O L	other (apechy)					
P.O.	requires that the dea been signed by the s should be detached	by PI	Part II. Other significant conditions contributing to death but not resu	lting in the ur	nderlying cause given in	Part I.	23e. Did tob	acco use cont	ribute to the	e cause of death?
S,	uires in sign	edk					1 □ Y€	es 2 No	3 Prob	ably 4 🗌 Unknown
Records,	iw rec	Completed					24a. Was ar autops		Were autop	sy findings available appletion of cause of
Be.	The law ate has page 2	E					perform	ned2	death?	
ta	cian; ertific ector,	Be	25. Was case referred to medical examiner? Hospital:			Death (Check	only one)			
Ę.	Physi this c	요	1 Pes 2 No 1 Inpatient 2 E	ER/Outpatien 28b. Time of			ne 5 🔀 Reside			- 11
0 0	ding h. h. After fune	ate	Natural 5 Pending (Month, Day, Year)	injury	28c. Injury at work? M 1 1 Yes		8d. Describe ho	w injury occurr	ed	
sio	Attendi r death ctor; A by the f	Certificate:	\$ □ Accident Investigation 3 □ Suicide 6 □ Could not be 4 □ Homicide determined 28e. Place of Injury - At horizontal interpretation	me, farm, stre			8f. Location (Str	eet and Numb	er or Rural F	Route Number,
Division of Vital	al or safte		building, etc. (Specify)				City or Town			
_	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours affer death. To the Funeral Director: Affer this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowle	edge, death c	occurred at the time, date	e and place, and	d due to the cau	se(s) and man	ner as state	d.
	To the H within 24 To the Fu complete	Me	(Check 2 ☐ Medical Examiner: On the basis of examination only one) 3 ☐ Certifying Nurse Practitioner: To the best of m		death occurred at the time	e, date and plac	ce, and due to the	e cause(s) and r	nanner as st	ated.
	with con-		29b. Signature and title of certifier		29c. License numb			9d. Date signed		
			- AVINO		1 400 2	0075	> \	3-6	ナイト	2012
SW	9		30 Name and address of person who completed cause of death (Item:	23a) (Type, P	Merchants	1000	Suit >	x 12	514	2012 20651 dtown MI
٦.	Stat	e	31. Date filed (NATA) 2 Yes 2 2012 22. Registrar's Signal	ure		LUNCE	JUTE d	1) LEI	XIGY	a Loan W
	Registra		MARK & D ZUIZ ARAMA A.	7						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Helsel Harriet 4:55 P. Medical **Examiner** 4a. Facility Name (if not institution, give street and number Town, or Location of Death County of Death netari Gler 6. SeA 1 M 2 X 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Days Hours Min. 63 **Director** 217-46-4505 09,1949 Feb. Usual Residence of Decedent show 10a. State 10b. County ŧ 10c. City, Town or Location 10d. Inside City Limits Director r 28a-f st notified a MD Anne Arundel Severna Park 1 Yes 2 X No 10e Street and Number ō 10f. Zip Code iral", or items 23a or Examiner must be 10g. Citizen of What Country? Funeral 647 Saltzman Road 21146 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 X No If Yes, Give Year or Dates. within 72 hours after Baltimore, Marylahd 21215-0036 1 ☐ Yes 2X No Specify: White "natural", Completed 3 Widowed 4X Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) than, Elementary/Seconday (0-12) College (1-4 or 5+) Day Care Provider Day Care 12 other Be Page 1 and 2 should be filed nent of Health and Mental Hy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental H

27 is marked of

traumatic ever ည Henry M. Gibbs Margaret Willhelm 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. John Helsel, III / Son 2 Ridgeway Drive Ridgely, MD 21660 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Mar. 14, 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 2012 Metro Crematory, INC. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Barranco & Sons, P.A. Severna Park Funeral He
495 Ritchie Hwy, Severna Park, MD 21146 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or hear failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) to (or as a consequence of Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Day Pregnant at time of death Month Vear Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performag? Yes 2 \(\bar{\Delta} \) No death? 2 X/No 1 🗌 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 **N**No Hospital Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 1 Natural 2 Accident 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5 Pending work М 1 🗌 Yes 2 🗌 No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \square Homicide determined building, etc. (Specify) Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29c. License number

State Registrar

31. Date filed (Month, Day, Year) 6 2012

Name and address of person who completed cause of death (Item 23a) (Type, Pri

32. Registrar's Signature

s. par

		PI	ease	Type or	Pri	nt in I	Black	ndel	ible Inl	k. Ens	ure A	II Copie	s Ar	e Leg	jible.		
		_ For		State o	f M	arylan	d / Dep	artm	ent of H	lealth	and M	lental Hy	gien	е			
		State Registrar					Ce	ertific	ate of L	Death			Reg. N	lo. 2		2 10	1,60
Physicia	,	1. Decedent's Name (First, Mic	ldle, Las	t)								2. Date of De	_	Dav	Year	3. Time of De	eath
Medic	al	MERIDA SNYDER HARR										March			0 ^{Year} 2		a™
Examin	er	4a. Facility Name (if not instituted) 209 Harrison			iber)			4b. 0	ity, Town, or ROC	Location			4	lc. County M		omery	
Funeral		5. Social Security Number	6. Se		7. Ag	e (In yrs. Ia	ast birthday	If U	nder 1 Year hs Days	If Under Hours	Min.	8. Date of Bir (Month, Da)		nplace (State or F ntry)	oreign
Director		578-56-5089 Usual Residence of Deceder		□м 2 🗶 ғ		71	Yrs.					Sept.1	0 1	940	Wash	nington,	D.C.
land show d at	ō	10a. State 10b. Cou				10c. City	, Town or L	ocation.				-				10d. Inside City I	∟imits
Maryla Ba-f	rect	MD Mo	ntgo	mery			Ro	ckvi	lle							1 Yes 2	☐ No
the land	Ö	10e. Street and Number		*				10f.	Zip Code				10g. (Citizen of	What Cou	intry?	
h with	Funeral Director	209 Harriso	n St							0850				ited	Stat	tes	
r iten		11. Marital Status 1 ☐ Never Married 2 📉	A control	12. Was Dece Armed Fo	rces?		5. 13	. Was De If Yes, s	cedent of H pecify Cuba	ispanic Or an, Mexica	rigin? (Spe .n, Puerto	cify Yes or No- Rican, etc.)			e - Ameri ck, White	ican Indian, , etc.	
s after	ed by	3 Widowed 4 Divor		1 ☐ Yes If Yes, Giv Year or Da	e	INO		1 🗆 Ye	s 2 No	Specify	<i>':</i>			Specify	· Wh:	ite	
houn	Sete	15. Dece (Specify only hi	dent's Ed	ducation			16a. Dec	edent's l	Jsual Occup work done o	ation	at of worki	ina	16b.	Kind of B	susiness/li	ndustry	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	Elementary/Secondary (0-1		College (1	-4 or 5	5+)	life.	DO NOT	use retired) acher	zaring mos	31 01 1101111	rig		Fdu	catio	on	
led wi Hygid other ent, tl	Be (12 17. Father's Name (First, Middle	e, Last)	()				acrici	18. Moth	ner's Name	e (First, Middle,	Maide				
d be fi dental rrked tic ev	욘	Harold Ela	m S	nyder						Eth	nel	Linton					
should and N is ma		19a. Informant's Name/Relation	nship (Ty	pe, Print)								l Route Numbe					
nd 2 s ealth m 27		Louis D. Harr	ingt	on / Hı	ısba					st.,	Roc	kville,	Ма	ryla	nd ———	20850	
ge 1 a t of H if itel		20a. Method of Disposition 1 Durial 2 X Cremat	on 3 🗆	Removal from	State	20b. P	lace of Disp emetery, cr		Name of or other plac	ce)	[Date	20c.	Location -	- City or T	Town, State	
it. Pag rtmen rtant: ijury		4 Donation 5 Othe	r (Specif						n Cre		3/17					, Virgin	
permi Depar Impo any ir		21. Signature of Funeral Service	e Ligens		_							iel H. tonsvil				ral Home	:
		23a. Par 1. Enter the disease	or comp	olications that	caused	the deat				_			_	rial	yıaık	Approximate	
Physician/		shock, or heart failure. Li Immediate Cause (Final	st only o	ne cause on ea	och line	e.	+ +	ic	M	elai	h an	na (M	-1	S-v	ant	Interval Betwe Onset and Dea	ath
Medical		disease or condition resulting in death)	-	a. Due to	(or as	a consequ	ence of):			- (- (.	- (0)	100 (1)		ngri	2000		,
Examiner	<u>_</u>	Sequentially list conditions,		b)~	an	Me	fa	sta	mis	,				_	3 yea	us.
sit sd	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	⋞	Due to	or as	a consequ	ience of):				2 A 1						
executed an and ırial-transit	Exa	that initiated events resulting in death) Last	1	c. Due to	(or as	a consequ	ience of):	7	α	Me	23 (
cate be ex physiciar s the buri	ical		L	d													
ificate ng ph) as th	Med	IF FEMALE:															
eath certifica attending pl	ian/	23b. Was decedent pregnant in the past 12 months?			Birth	2 Feta	death 3		oic pregnanc	СУ					ate of deli	very Day Yea	ar
Attending Physician: The law requires that the death certificate be ar death. ector: After this certificate has been signed by the attending physici by the funeral director, page 2 should be detached for use as the bu	Physician/Medica	1 Yes 2 No		4 ∐ Preg 9 ∏ Unki		t time of c	leath 5	☐ Othe	r (specify) _					IVIC	JIIIII	Day 168	u .
requires that the der been signed by the s should be detached	by Ph	Part II. Other significant cond	litions co	ontributing to d	leath b	out not res	ulting in the	underly	ng cause giv	ven in Part	t I.	23e. Did t	obacco	use cont	tribute to	the cause of dear	th?
uires t n sign uld be	q pe	1 Yes 2 No 3 Pro								obably 4 🗌 Un	known						
w req	Completed											24a. Was				opsy findings ava	
sician: The law certificate has lirector, page 2	Com												rmed?		death?	2 No	
ysician: is certifica director,	Be (25. Was case referred to medi- examiner?	-	11 25-15						ace of Dea	ath (Check	(only one)					
Physic this or	ပ္	1 Yes 2 No		_	_	-	ER/Outpati		_	4 L N		me 5 Resid				fy)	
ding F h. After funer	ate	Natural 5 🗆 Per				y, Year)	injury	M	28c. Injur work			28d. Describe I	now inji	ury occurr	red		
ol or Attendir s after death. I Director: Aft d in by the fu	Certificate:	3 Suicide 6 Co	estigation ald not be ermined	e 28e. Place			me, farm, s			700 2 2	- 110				er or Rura	al Route Number,	
7 4 7 1		4 E Homodo do	-	buildi	ng, etc	c. (Specify	·)					City or Tov	vn, Sta	te)			
To the Hospital of within 24 hours and To the Funeral Discompletely filled in	Medical											nd due to the c				ited. ause(s) and mann	er stated.
the lathin 2 the lathin 2 the lathin 2 the lathin 2 mmple	Ň	only one) 3 Certify 29b. Signature and title of cert		e Practitione	: To th	e best of n	ny knowledg	ge, death	occurred at t 29c. License		ate and pla	ace, and due to				stated. Day, Year)	
7 × 7 0			Λ1.	2 1. 10		٨	ıb		T		903	0	2	11/	/11	3	
		30. Name and address of pers	on who c	completed caus	se of d	leath (Item	23a) (Type	, Print)						116	1-1	``	
10		URVIMEH	TA	149	53	_ ` _			ROVE	RD	B	ockl	112	LE	M	DROS	350
Stat Registra		31. Date filed (Month, Day, Yea	9 20	32.5	egistra	ar's Signat		back	1								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		-	State Registrar	ŕ	Ce	ertificate of L	Death		Reg. No.	2012	2 10	4/1
	Physicia		1. Decedent's Name (First, Middle, Last)	ruff.				2. Date of De Month March	ath Day	y Year 2012	3. Time of E	Death A M
**	Medic Examin		4a. Facility Name (if not institution, give st	reet and number)		4b. City, Town, or	Location of De			County of Death		
فربد			Genesis HealthCa	re		Waldo				Charles		
	Funeral Director		5. Social Security Number 6. Sex 1 578-58-7986		s. last birthday Yrs.) If Under 1 Year Months Days	If Under 24 H Hours M		y, Year)	Cou	place (State or ntry) ington	
	nd how at	_	Usual Residence of Decedent 10a, State 10b. County	10c.	City, Town or I	_ocation	-				10d. Inside City	/ Limits
	arylar a-fsl fied a	30			,,						1 ★ Yes	2 🗆 No
	or 28 noti	ä	Md Prince Ge 10e. Street and Number	orge's		Clinto 10f. Zip Code	11		10a, Cit	izen of What Cou	intry?	
	with the 23a cast be sat be	Funeral Director	8304 Bellefonte L	ane		207	35		J	USA	•	
	eath tems er mu	Ě		2. Was Decedent Ever in	U.S. 13	I. Was Decedent of Hi	spanic Origin?	(Specify Yes or No-		14. Race - Amer		
9200-61212	filed within 72 hours after death with the Maryland theylone. Hygione. All Hygione	þ	1 ☐ Never Married 2 ☐ Married 3 ፟፟፟፟፟፟ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 😿 No If Yes, Give Year or Dates.		1 ☐ Yes 2 🔀 No		erto nicari, etc.)		Black, White Specify: Whi		
r C	2 hour "natu dical	plet	15. Decedent's Edu (Specify only highest grade		16a. Dec	edent's Usual Occup	ation during most of v	vorkina	16b. Ki	ind of Business I	ndustry	
2	hin 72 ne. than e Me	Completed	Elementary/Seconday (0-12)	College (1-4 or 5+)	Ìife.	DO NOT use retired)	_		PG	County	tion	
2	d with Hygier ther int, th	as l	9		Cafe	eteria Ass				rd of Ed	ucation	1
anc		To E	17. Father's Name (First, Middle, Last) Omer Miller					Name <i>(First, Middl</i> e, a Shiflet	iviaiden :	Surname)		
Maryland	1 and 2 should be filk of Health and Mental item 27 is marked o other traumatic eve		19a. Informant's Name/Relationship (Type	e. Print)	19h Ma	iling Address (Street a			er. City or	Town, State, Zip	Code)	
_	12sh althar 27is rtrau	- 1	Terri Huff / Dau		11.0	Westdale				20601	,	
ē,	1 and of Heal item :		20a. Method of Disposition	20b	. Place of Dis	position (Name of rematory or other place		Date		ocation - City or	own, State	
Ē	Page nent c ant: If		1 🔀 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	emoval from State		.coln Ceme		/23/12	Bren	twood,	Md	
Baltimore,	permit. Page 1 a Department of I Important: If its any injury or of once.		21. Signature Funeral Sprice Licensee)		22. Name and Addres					lome 20722	
			23a. Part 1. Enter the disease, or compli-	cations that caused the de						,	Approximate	
,	hysician/	300	shock, or heart failure. List only one Immediate Cause (Final	cause on each line.	nd S	tage	COPT	\mathcal{I}		,	Interval Betw Onset and D	
j	Medical		disease or condition resulting in death)	Due to (or as a conse		A		A 5				
	Examiner		Sequentially list conditions, b		ろかり	chogen	ic co	Bano	ma	,		
	n #	Examiner	if any, leading to immediate cause. Enter Underlying	Due to (or as a conse	equence on.	V						
	and trans	xan	Cause (Disease or iinjury that initiated events resulting in death) Last	Due to (or as a conse	equence of):	· · · · · · · · · · · · · · · · · · ·						
	ifficate be executed by physician and as the burial-transit		resulting in death) Last		34001100 01/1							
2/60	phys phys the l	Medical										
20	nding use as		IF FEMALE: 23b. Was decedent pregnant 23	Bc. If yes, outcome of preg						23d. Date of deli	very	
POX	e atte	icia	in the past 12 months? 1 Yes 2 No	1 Live Birth 2 F 4 Pregnant at time of 9 Unknown		☐ Ectopic pregnand ☐ Other (specify)	У			Month	Day Ye	ear
	by the tache	Physician/	9 L Unknown					1				
7.	is that igned be de		Part II. Other significant conditions con	Iributing to death but not i	resulting in the	cause give	ren in Part I.			use contribute to ☐ No 3 ☐ Pr	~ 4	
ras	equire een s rould	eted	Proxiety Depre	de Sus Cod	20-11	الرمهما	1					
ပ္တ	has b	Completed by	moxey veril	ויטומת	Jessi W	1.		 24a. Was auto 			opsy findings av ompletion of ca	
ř	r: The icate r, pag		25. Was case referred to medical			00.51	(D. II. (C	1 ☐ Yes			2 X No	
123	siciar certif irecto	m	evaminer?	ospital:		_ Othe	ace of Death (C	g Home 5 \square Resi	d-= 6	: Other (Cresi	5.4	
or Vital Records,	g Phy er this eral d	e: To	27. Manner of Death	28a. Date of injury	28b. Time	of 28c. Injur	/ at	28d. Describe I			у)	
ָ מ	ath. r: Aft	icat	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	injury		Yes 2 No					
DIVISION	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Within 24 hours after death. Within 24 hours after death. Completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spec		street, factory, office		28f. Location (City or Tox		d Number or Run)	al Route Numbe	∍ <i>r</i> ;
	Hospita 24 hours Funeral sted fille	Medical	(Check 2 Medical Examine	cian: To the best of my kno er: On the basis of examina	tion and/or inv	estigation, in my opinio	on, death occurr	ed at the time, date a	and place	, and due to the c	ause(s) and man	ner stated.
:	o the vithin o the omple	_	OOL Cianature and title of cortifier	Practioner: To the best of		20a Ligano	numbar		004 D-4	to sinced (Month	Day Your	
	- S F O)	what	_	D	71199		0	3/19/	2012	
	^		30. Name and address of perspn who cold	npleted cause of death (It	em 23a) (Type	, Print)	ΩΙΩ	of Cto 12	G1.	121.2	ni m	10
	44		Vo. Josjin Vazr	appilly,	6934	+ Aviano	1010	ロップトゥ	, or w	un 19wi	ri Uz, II.	レ
		•	31. Date filed (Month, Day, Year)	32. Redistrar's 20	natura P							

Registrar DHMH 17 Rev 7/2009

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 10 ZOIZ Month 3 Physician/ 04:03AM Emmett John Howel Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c_County of Death Baltimore Univ. of MD Baltimore Med. If Under 1 Year | If Under 24 Hrs 7. Age (In yrs, last birthday) 53 9. Birthplace (State or Foreign 8. Date of Birth 6. Sex Funeral 5, Social Security Number 579-88-9906 Hours 09/29/1958 Maryland 1 ¥M 2 □ F Director 28a-f show 10d. Inside City Limits ms 23a or 28a-f shomust be notified at 10b. County 10c City, Town or Location Washington filed within 72 hours after death with the Maryland Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 20019 Citizen of What Country? 10g. Citiz 324 Ridge Rd. SE Apt#12 Funeral items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Examiner Armed Forces? Black, White, etc. Specify: Black ō þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates "natural" Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry self employed al Hygiene. life. DO NOT use retired) Lands caping Elementary/Secondary (0-12) College (1-4 or 5+) traumatic event, Be permit. Page 1 and 2 should be filed. Department of Health and Mental Hw. Important: If item 27 is markany injury or other: 18. Mother's Name (First, Middle, Majden Surname) NeILIE Howell 17. Father's Name (First, Middle, Last)
Everett Griffin 9 19b. Mailing Address (Street and Number or Bural Route Number, City or Town, State, Zip Code) 5648 Blaine St. NE Washington, DC 20019 19a. Informant's Name/Relationship (Type, Print)
Nathaniel Howell 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date Heritage Cemetery 1 ABurial 2 Cremation 3 Removal from State 3/21/12 Waldorf, 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee \(\text{\text{\$\signature}} \) \(\text{\text{\$\signature}} \) \(\text{\text{\$\signature}} \) \(\text{\text{\$\signature}} \) 22. Name and Address of Facility NE Washington DC 20019 Dunn & Sons-5635 Eads St. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ HIV disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or Injury that initiated events resulting in death) Last and burial-tra Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death
Unknown 5 Other (specify) been signed by the a should be detached 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No has page 2 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director; After this certificate funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 XNo 1 🗌 Yes 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Manper of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 5 - Pending 1 Natural Accident Investigation filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one) 29b. Signature and title of certifier 29c. License number 3/10 Name and address of person who completed cause of death (Item 23e) (Type, Print)

Meng wang 22. S. Greene St. Battimore MD

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

21

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - State Registrar 22 State Th. N. 2020, 04 Per 2012 The Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year LAWRENCE ADOLPHUS HYMES 12:26 PM 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death St. A gnes Hospital Baltinore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 202-30-0857 Director 1 🛛 M 2 🗆 F 77 08/28/1934 Pennsylvania Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location notified at 10d. Inside City Limits Director MD Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Examiner must be 23a Funeral 21229 U.S.A. 3330 Wilkens Avenue items 12. Was Decedent Ever in U.S. Armed Forces?

1

1 Yes 2 □ No

If Yes. Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ö þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: White "natural" Completed 3 X Widowed 4 □ Divorced 1957 Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Fire Restoration Maintenance Worker 11 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental His marked o ၉ Myrrel Housel injury or other traumatic Emery Hymes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 505 Monroe Street, Everett, PA 15537 Hazel M. Calhoun / Sister 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗓 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) Schellsburg Cemetery 03/05/2012 Schellsburg, PA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Upchurch, Funeral Home, P.A.

202 Greene St. Climber Land, MD 21512

EVENERAL TO THE PROPERTY OF THE PROPERTY 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the cisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final Onset and Death Physician/ Preumonia Days disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Examine burial-transi Cause (Disease or injury that initiated events resulting in death) Last Ventricular Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 the ! LAWRENCE IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year signed by the a' Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s autopsy performed this certificate 2 🗆 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No ၉ + ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: Natural 5 \square Pending work? 2 Accident
3 Suicide
4 Homicide Yes 2 No Investigation 6 🗆 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 24064 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

APR 0 3 2012

Cation

900

32. Registrar's Signature

Avenue

MD-21229

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 14:45 P.M Carol Ann Hancock 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Meritus Medical Center Hagerstown 8. Date of Birth
(Month, Day, Year)
Dec. 17, 1947 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours 216-48-6426 64 Maryland Director 1 🗆 M 2 🗴 F Yrs Usual Residence of Decede 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State an "natural", or items 23a or 28a-f sho Medical Examiner must be notified at Director Hagerstown 1 XYes 2 No Washington Md. 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 21740 U.S.A 428 Stratford Ave. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Force Black, White, etc. 1 Yes 2 No
If Yes, Give X
Year or Dates. 1 Never Married 2 Married þ Maryland 21215-0036 1 Yes 2 No Specify. Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Home the Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) should be file and Mental H is marked ot Dorothy L. Plantz ပ John W. Haberbeck permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic. other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 428 Stratford Ave. Hagerstown, Md. 21740 19a. Informant's Name/Relationship (Type, Print)

Vernon L. Hancock (Husband) Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 24, March 2012 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Smithsburg, Md. Smithsburg Crematory 4 Donation 5 Other (Specify) 22. Name and Address of Facility Signature of Funeral Service Licensee 12525 Bradbury Ave. M01414 J.L. Davis Funeral Home Smithsburg, Md. 20 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death mmediate Cause (Final Physician/ hirator disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner burial-transi Cause (Disease or injury hronic that initiated events resulting in death) Last Due to (or as a consequence of attending physician Physician/Medical P.O. Box 68760 use as the 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 funeral director, page 2 1 ☐ Yes 2 ☐ No this certificate B Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certifica 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ျှ 2 🔀 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the I within 2 only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 10 gr 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Khalid M. Waseem 1126 Opal Ct. Hagerstown, Md. 21740 31. Date filed (Month, Day, Year APR 0 3 2012 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death . 2<u>012</u> Physician/ March 14 Рм Harold Wayne Inman 5:35 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Talbot Talbot Hospice House Easton Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Days (Month, Day, Year) Months Hours Min Director 352-20-8126 1 □xM 2 □ F 83 3/23/1928 **Illinois** Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location notified at Director Maryland Talbot 28a-f Easton 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be r Funeral 29731 Penny Lane 21601 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian or than "natural", or iter the Medical Examiner Armed Forces? Black White etc. should be filed within 72 hours after and Mental Hygiene. ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed 46 - 5115. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Terminal Manager Transportation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Department of Health and Ment Important: If item 27 is marke any injury or other traumatic Raymond Inman Ella Mae Newton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mildred M. Inman - Wife 29731 Penny Lane, Easton, MD 21601 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place. ■ Burial 2 □ Cremation 3 □ Removal from State Lakemont Mem Gardens 3/17/2012 Davidsonville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility John M. Tavlor Funeral Home 147 Duke of Gloucester St, Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph si ian CONFEDUR disease or condition resulting in death) LOAKS Medical Due to (or as consequence of): Examiner curtic Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine COPD Cause (Disease or injury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Deabeles wellitus Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No Day Month Year Pregnant at time of death 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by director, page 2 should be almal telorillation 1 Yes 2 No 3 Probably 4 Unknown conouncy atlery disease 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an 24 hours after death. Funeral Director: After this certificate has autopsy Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 🕅 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA completely filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 5 Pending 1 Natural injury Accident Investigation

within 2 To the I

State

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Syed Ali, M.D. 8579 Commerce Drive,

31. Date filed (Month, Day, Year)

6 Could not be

determined

3 Suicide

29a. Certifier

4 Homicide

only one

MAR 19

Suite 108, Easton, MD 21601

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year,

Registrar

1 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D 00 46020

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March June 20T2 Lee Johnson 4:00 a^M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Caroline Nursing & Rehab Caroline Denton Social Security Number 6. Sex 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Age (In yrs. last birthday) If Under 8. Date of Birth **Funeral** Min. 1 M 2 Sz F Jume^{h, 9ay, Y}1931 Maryland 214-28-3164 80 **Director** Usual Residence of Deceden 10a. State 10b County be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits must be notified at Director MD Caroline Denton or 28a-f 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a 520 Kerr Avenue 21629 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian er than "natural", or ite the Medical Examiner Armed Forces Black, White, etc. þ 1 Never Married 2 Amarried Maryland 21215-0036 ☐ Yes 2 X No If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: white Specify: 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) at Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) telephone company plant assigner Be traumatic event, 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) and Mental I ည Charles Garey Marguerite Cox 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health aitem 27 i Cheryl J. Tubman daughter 26678 Miles River Road, Easton, MD injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important; If ite any injury or ot cemetery, crematory or other place) 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Maryland Veterans Cemi. 3/19/12 4 Donation 5 Other (Specify) Hurlock, MD permit. 22. Name and Address of Facility Thomas Funeral Home P.A. 21. Signature of Funeral Service Licenses 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Pnysician Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury a d that initiated events resulting in death) Last Due to (or as a consequence of) burialattending physician I for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physicis P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year been signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? this certificate has ral director, page 2 autopsy performed 1 Yes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 2 No မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation M the 2 Accider
3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospital or Atte within 24 hours after de To the Funeral Directo completed filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, State NAR 15 201 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ROBIN Τ. **JENIFER** MARCH 2012 04:53 a M 4c. County of Death 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Southern Maryland Hospital Clinton Prince Georges Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Davs Hours Min (Month, Day, Year) 215-70-2146 1 □ M 2 🕱 F Yrs. April 19, 1957 MD 54 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Prince Georges Suitland 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? USA 5812 Suitland Rd. 20746 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces? 1 Yes 2 No Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12th DC Government Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Betty Randolph Francis Jenifer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty J. Jenifer - Mother Suitland Rd. Suitland, MD 20746 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 3-27-2012 Cedar Hill Cemetery Suitland, MD 21. Signature of Euneral Service Licenses 22. Name and Address of Facility Marshall-March Funeral Home of Maryland 4308 Suitlnad Rd. Suitlnad, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Houte Atherosciente Cardiovascular biseme resulting in death) Due to (or as a consequence of) Hypertensim

Physician/ Medical Examin

per nit Der ar Imror any in

Physician/

Medical

10a. State

MD

Examiner

Funeral

Director

28a-f shov

ò

items 23a

ò

nit. Page 1 and 2 should be filed within 72 hours after earlment of Health and Mental Hygiene. cortant: If item 27 is marked other than "natural", or injury or other traumatic event, the Medical Examis

Baltimore, Maryland 21215-0036

Examiner must be notified at

Funeral Director

þ

Completed

Be

٩

and To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: A completely filled in by the fi

Division of Vital Records, P.O. Box 68760

21	
	0
	į
	ап
	Ĕ
	ja .
	dic
	Me
	l/l
	cia
	ysi
	P
	ý
	Ď.
	ete
	ם
	Ö
	O
	ď
	은
	te:
	ca
	ij
	Ö
1	a
	dical Certificate: To Be Completed by Physician/Medical Examiner

Me

maryland 31. Date filed (Month, Day, Year)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of the consequence o	uence of):	îstus					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pregnation 1 ☐ Live Birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3 🔲 Ectopio				23d. Date of del Month	livery Day	Year
Part II. Other significant conditions	•		g cause given in Part I.			se contribute to		
- Rehal tra		ne to e	nactage		topsy rformed?	death?	topsy findings completion of	available cause of
25. Was case referred to medical			26. Place of Death (Ch	eck only one)	- (
examiner? 1 Yes 2 No	Hospital:	₽R/Outpatient 3 □	Othor	Home 5 \square Re	sidence 6	Other (Spec	ify)	
27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident ☐ Investigation		28b. Time of injury M	28c. Injury at work? 1 □ Yes 2 □ No	28d. Describ	e how injury	occurred		
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined			actory, office 28f. Location City or To			l Number or Rui	al Route Nun	nber,
(Check 2 Medical Exar	ysician: To the best of my know niner: On the basis of examination irse Practitioner: To the best of	n and/or investigation, i	n my opinion, death occurred	d at the time, dat	e and place,	and due to the o	cause(s) and m	nanner stated
29b. Signature and title of certifier	\wedge	2:	c. License number		29d. Date	e signed (Month	, Day, Year)	

5068

EMAHAJAN. MD.

SYYVATTS ROAD CLINTOND

SUYTLEVA

DHMH 17 Rev 06-2011

State Registrar

7503

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A NIL

center

32. Registrar's Signature

Ant 1920H

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 3 Andrew Jeremiah Jackson Physician/ 21:10P M 20 T2 Medical 4a. Facility Name (if not institution, give street and number)
Southern Maryland Hospital 4b. City, Town, or Location of Death Clinton **Examiner** 4c. County of Death Prince Georges Social Security Numbe If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 88 Days Hours 05/9/1923 577-20-5377 1 XM 2 🗆 F Maryland Director 28a-f show 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location Cheltenhem 10a. State Prince Georges Directo 1 ¥ Yes 2 □ No 10e. Street and Number 10704 Heatherleigh Dr. 10f Zip Code 20623 10g. Citizen of What Country? Funeral USA 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Black Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Contractor Painter other traumatic event, Be 17. Father's Name (First, Middle, Last)
John Thomas Jackson 18. Mother's Name (First, Middle, Maiden Surname)
Madeline Fletcher 19a. Informant's Name/Relationship (Type Print)
Anthony Russell/brother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10704 Heatherleigh Dr. Cheltenhem, MD. 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot 1X Burial 2 \square Cremation 3 \square Removal from State Cheltenhem Cem. 3/22/12 Cheltenhem, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Dunn & Sons- 5635 Eads St. NE Washington DC 20019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Thereoscleratic andio Varalen Discure Physician/ disease or condition resulting in death) Medical Examiner Livell Securitally list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) been signed by the should be detached 1 L Yes 2 L 9 Hinknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 o autopsy performed? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 - No Certificate: To 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide iniury 5 Pending Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined the Hospital Medical 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one)

30

DHMH 17 Rev 06-2011

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Spill

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1174

32. Registrar's Signature

Sidakoul, M.

29c. License number

29d. Date signed (Month, Day, Year)

living 1 + m ad the lot of washing on MA 20786

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Polly Sue Kibler 2012 7:00 March Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hospice of Queen Annes Centreville Queen Annes If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) (arch 11, . Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛭 Months Hours Country) Marvland 59 216-64-8470 1952 **Director** Usual Residence of Decedent show 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho Director 1 Yes 2 X No MD Caroline Greensboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13680 Drapers Mill Road 21639 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian Armed Forces?
1 ☐ Yes 2 Î No Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify.White 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry should be filed within 72 h and Mental Hygiene. 7 is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) Seamstress Self Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Robert Jeffers Betty Thompson Jeffers permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daughter 219 Georgetown Road Annapolis, MD 21403 <u>Lisa Christine Kubaska</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greensboro Cemetery March 10,2012 Greensboro, MD . Signature of Funeral Service Licenses 22. Name and Address of Facility PO. Box 160 Greensboro, MD 21639 Fleegle and Helfenbein Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ PANCREATIC CANCER MONTHS disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Exami executed burial-transi Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): been signed by the attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe page 2 this certificate 1 Yes 2 No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: ည 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Hospite Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending Accident Investigation within 24 hours after deat To the Funeral Director: completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🔲 Homicide determined Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

State Registrar (Check only one)

29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D3988

29d. Date signed (Month, Day, Year)

3 6 2012

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 15:33 P M Physician/ march 0 201 Medical (if not institution, give street and number or Location of Death Examiner 4c. County of Death chingo. timore 101743 4 . Age (In yrs last birthday) Year If Under 24 Hrs. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 430-06-5482 Director 1 🗌 M 2 🔀 F 44 11/05/1967 VA Usual Residence of Dece shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland notified at Funeral Director 28a-f 1 Yes 2X No MD Howard Airy 10e. Street and Numbe 10f. Zip Code d 10g. Citizen of What Country? must be with 23a 16690 Blooms Lane 21771 USA items Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status ral", or iter Examiner 14. Race - American Indian. Armed Force Black, White, etc. Completed by 1 Yes 2 No 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: "natural", 3 - Widowed 4 - Divorced Year or Dates White traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Technical Editor McGraw Hill Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname ၉ Emeiel Thrasher Marilyn Flynt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Tadd Kippeny/husband 16690 Blooms Lane, Mt. Airy, MD 21771 or other 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or oth 20c. Location - City or Town, State cemetery, crematory or other place) ☐ Burial 2 🖫 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Crematory 03/14/2012 | Frederick, MD permit. e of Funeral Service Licenses 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part 1. Enter the disea shock, or heart failure. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, It only one cause on each line. Interval Between Onset and Death Immediate Cause (Final neumonia Playsiciani disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): burial-transi Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical certificate be Box 68760 the as attending IF FEMALE nse yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Hospital or Attending Physician: The law requires that the death Month Day 5 Other (specify) Pregnant at time of death signed by the at Id be detached fo 1 Yes 2 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown Completed 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 certificate has autopsy perform Yes completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 2 No 1 Yes ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred Natural 5 Pending injury death. Accident Investigation 24 hours after deat Funeral Director. □ Acciden
 □ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one 29b. Signature a 00046852

Registrar DHMH 17 Rev 06-2011

6

30. Name and address of person who

Neuin M. 31. Date filed (Month, Day, Year, npleted cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

ASEAN.

Katz, MO

5

600 North Wolfest

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<u>012</u> Physician/ Month 19 2:00 a.m. Onisim Krasnokutsky March Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Mary's 417<u>00 Mattingly Street</u> Leonardtown Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth -9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Months Days Hours Min. **Director** 212-32-0925 1 XM 2 □ F 78 09/05/1933 Yugoslavia Usual Residence of Decedent show 10a. State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland at Director or 28a-f sh notified a 1. Vet 2 No Maryland St. Mary's Leonardtown 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? "natural", or items 23a o Funeral 20650 41700 Mattingly Street United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 XYes 2 □ No Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White Completed 3 Widowed 4 Divorced Page 1 and 2 should be filed within 72 hour ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natu iury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) should be filed with h and Mental Hygien 7 is marked other th Master Machinist Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Unknown Michael Krasnokutsky 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23275 Hollywood Rd., Leonardtown, MD 20650 Victor Krasnokutsky / Son permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr once. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 XCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield Echols Cre 03/20/2012 Charlotte Hall, MD 21. Signature Deneral Semine Lice see

Edward N. Brinsfield, 22. Name and Address of Facility Brinsfield Funeral Home, M00052 22955 Hollywood Road, Leonardtown, MD Jr. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ small cell lune non disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed for use as the burial-transi Cause (Disease or injury that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year 5 Other (specify) Month Day Pregnant at time of death 1 Yes 2 I should be detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No page 2 completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \square Nursing Home 5 X Residence 6 \square Other (Specify) Hospital: 2 No Certificate: To ER/Outpatient 3 DOA 1 Inpatient 2 I 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural $5 \square$ Pending 1 Yes 2 No within 24 hours after death.

To the Funeral Director: A Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

3) Rme

Hospital

31. Date filed (Month, Day, Year) State MAR 20 Registrar

29a. Certifier

29b. Signature and title of certifier

CATH

Medical

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 23415 three Notch Road California, MD

20619

29c. License number

D20686

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month. Day, Year)

Gurden S. Chhabra MD

march 19th

Etertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 | 2 For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 6:32AM March Shirley Catherine Kenney Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Cumberland **Examiner** Allegany Western MD Regional Medical Center 7. Age (In yrs. last birthday) Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Days Hours 220-32-4132 02-04-1935 Maryland Director 1 - M 2 X F 28a-f shov notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Allegany Mt. Savage MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 ral", or items 23a or Examiner must be r Funeral U.S.A. 21545 16020 Foundry Row 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates White Specify: "natural", 3 ₩idowed 4 □ Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home should be filed with and Mental Hygien ris marked other the Be 18. Mother's Name (First, Middle, Maiden Surname)

Myrtle Winebrenner Rice 17. Father's Name (First, Middle, Last) William Rice 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important: If item 27 is 1 any injury or att 15713 Iron Rail Street Mt. Savage, MD 21534 daughter Dianna Kenney 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Veterans Rocky Gap 03-30-2012 | Cumberland, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Sowers Funeral Home, Har MOQ547 60 W. Main Street Frostburg, MD 21532 Sowers 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death cardiovascular disease Ph. ician/ Atherosclerotic disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions Due to (or as a consequence of). if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Exami To the Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IF FFMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death Unknown Division of Vital Records, P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of page 2 has autopsy perform death? certificate 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Other: 1 Yes 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) : After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No ours after death.

Ieral Director: Aft
filled in by the fur 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a

To the Funeral L

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 29b. Signature and title of certifier montockstu 00055325 March 27, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Walsh Rd Cumberland Bishop WONSOCK SHIN MD 925 32. Registrar's State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Thomas Tate Littrell 20.01 March 16. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Carrol1 Dove House Westminster Social Security Numbe 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Oct 20, 1944 214-42-3275 67 Maryland **Director** 1**XX**M 2 □ F Yrs 28a-f shov 10a. State 10b. County must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Frederick Thurmont Yes 2 No 10e, Street and Number 10f. Zip Code o 10g. Citizen of What Country? Funeral items 23a 21788 USA 10685 Salem Avenue 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, the Medical Examiner Armed Forces? Black, White, etc. ò by 1 Never Married 2XXMarried Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2X No Specify: Specify: White "natural" 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Asphalt Truck Driver 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ John Tate Littrell Elva Lorine Prater traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Coo Department of Health an Important; If item 27 is a any injury or other traunonce. Janice Littrell - wife 21788 10685 Salem Avenue, Thurmont, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 3-21-2012 Resthaven Memorial Frederick, Maryland 4 Donation 5 Other (Specify) re of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final et and Death Phytician/ disease or condition n Medical resulting in death) Examiner Sequentially list conditions, Examiner cause. Enter Underlying that the death certificate be executed Cause (Disease or injury that initiated events the burial-trai Due to (or as a consequence of) resulting in death) Last physician Physician/Medical P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy signed by the atter in the past 12 months? Day 5 Other (specify) Pregnant at time of death Yes 2 No g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 3 ☐ Probably 4 ☐ Unknown should Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy perform death? Yes To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 0 Hospital 2 No Other: 욘 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred **N**átural 5 Pending injury 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 🗆 Certifying Nurse Practition of 10 the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MDD16428

Registrar

DHMH 17 Rev 06-2011

8

State

30. Name and address of person who comple

Casper Cline MD

31. Date filed (Month, Day,

300 W. Ninth Street, Frederick, Maryland

217/01

se of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink., Ensure All Copies Are Legible.
Amend 24a per med cert G926, 4711/12 dk
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ^D2012 William Glenn Lane March13, 1:10 Рм Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Caroline 7771 Noble Road Federalsburg Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral 8. Date of Birth 9. Birthplace (State or Foreign June 3, Year 1959 1 XM 2 □ F Days Country) Maryland **Director** 52 Yrs 213-70-8742 Usual Residence of Decedent 28a-f show 10a. State 10b. County the Maryland notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland 1 Yes 2 No Caroline Federalsburg 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o Funeral 7771 Noble Road 21632 USA permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 Yes 2 No 1 ☐ Yes 2 XNo Specify: If Yes, Give Year or Dates. 3 Widowed 4 N Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 H.S. Grad. College (1-4 or 5+) Construction carpenter Housing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ William Hartley Lane Delores May Breeding 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Delores Lane/mother 7755 Noble Road Federalsburg, Maryland 21632 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
Concord Cemetery 1 XBurial 2 Cremation 3 Removal from State 3/17/2012 4 Donation 5 Other (Specify) Federalsburg, Maryland 21. Signary of Funeral Service Lice See Moore Funeral Home, P.A. 22. Name and Address of Facility 12 South Second Street Denton, Maryland 21629 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Approximate Immediate Cause (Final Physician/ Carcinoma disease or condition resulting in death) Medical Medical Examiner Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease on injury Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month 1 Yes 2 L 9 Unknown detached the -9 been signed by should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 KNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has funeral director, page 2 autopsy performed? death? After this certificate Yes 2 X N 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 KResidence 6 Other (Specify, 1 ☐ Yes 2 🔀 No ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death e Hospital or Attending Pl n 24 hours after death. e Funeral Director; After tl Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending work Investigation 1 ☐ Yes 2 ☐ No completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Pfactioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signature and title of certified မ 4.0. P30690 March 16, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) E. Martin 100 E. Carroll Street James Salisbury, Maryland 31. Date filed (Month, Day, 32. Registrar's Signatur

State

Registrar

MAR 2 1 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Walter H. Leyh March 2012 11:05 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Hospice Care Columbia Howard Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Min (Month, Day, Year) Director 220-20-2923 1**★** M 2 🗆 F Yrs 85 03/05/1927 Usual Residence of Decedent Marvland 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 Yes 2 No MD Howard Ellicott City 10e. Street and Number 10g. Citizen of What Country? Funeral 5211 Font Avenue 21043 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14 Bace - American Indian Armed Forces?

1 Ves 2 No
If Yes, Give 1945-46

Year or Dates. Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ★ Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Machinist Railroad Company 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ William Lehy, Jr. Carrie Marie Porter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. 9252 Brush Run Columbia, Maryland 21045 Cheryl L. Thornley/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ellicott City, MD 3/23/2012 22. Name and Address of Facility Harry H. Witzke's Family FH, Inc 21. Signature of Funeral Service Licenses uante Rahomos 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part U Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ ASTROINTESTINAL ORUS Medical resulting in death) ue to (or as a consequence of): Examiner COUMADIN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner ROSTHETIC Cause (Disease or injury attending physician and for use as the burial-tran that initiated events resulting in death) Last Physician/Medical The law requires that the death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CARDIOMYOPATHY Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed CHRONIL KIDNEY DISEASE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ARTERU DISEASE CORONARY 2 🗆 No 1 Tyes Division of Vital the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify Hospital: 2 No 1 🗌 Yes ျှ 1 Inpatient 2 I ER/Outpatient 3 I DOA 24 hours after death.

Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 28c. Injury at 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town. State Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certif D64395 MARCH 18,2012

Registrar

State

DANIEUE

124

6336 CEDAR LANE COLUMBIA, MD 21044

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

gistrar's Signature

DOBERMAN.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death

For State Registrar 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 16 th 2012 **Physician** 12:55PM MARCH Claire Helen Lydard /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A BALTIMORE AGNES HOSPITAL Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** Hours Days 1 □ M 2 T F Maryland Nov 17, 1924 87 215-22-1245 Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f show 1 ☐ Yes 2 ☐ No ortant: If item 27 is marked other than "natural", or items 23a or 28a-f si injury or other traumatic event, its Modical Examination in the most parties. Director Ellicott City MD Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21043 United States 5014 Avoca Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 ∐Yes **3** ∏ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. þ 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Pay Clerk Retail 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be h and Mental h Helen Zanto Frank Busch ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2...
Department of Health a Important: If item 27 is any injury or other trau LeRoy S. Lydard/husband 5014 Avoca Avenue Ellicott City, Maryland 21043 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Stanislaus Ceme. 3/21/2012 Dundalk, Maryland 21. Signature of Funeral Service Licer 22. Name and Address of Facility Harry H. Witzke's Family F.H. Inc 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 3 WEE Immediate Cause (Final disease or condition resulting in death) HEART FAILURE CONGESTIVE **Physician** /Medical Due to (or as a consequence of): Examiner PULMONALY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Attending Physician: The law requires that the death certificate be executed SLEEP DBSTRUCTIVE attending physician and Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months?
1 ☐ Yes 2 No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 🕱 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ∐Yes 2 XINo Certification: To 28d. Describe how injury occurred 27. Manner of Death

After this l or Attend after death Director: within 24 hours a

CYDARO

28a. Date of Injury (Month, Day, Year) 28b. Time of injury 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one)

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year) 29c. License number

0006586 MD 30. Name an address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated

EFFRYED BAITIMORE, MD 21227

State Registrar

5

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 1tem 20b per fh g927 5-11-12 vt State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Lillian Beatrice Lewis 12 2012 2:30 P. Medical March 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Prince George's Hospital Center Cheverly Prince George's Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days **Director** 579-36-3391 1 🗆 M 2 🔀 F 81 11/14/1930 Wash.,D.C. 28a-f show 10a. State 10b. County must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Md. 1 Yes 2 No P.G. Largo 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 500 Harry S. Truman Drive # 409 20774 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 255No
If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Examiner Black, White, etc. marked other than "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 🛂 No Specify: Completed 3 X Widowed 4 □ Divorced Year or Dates the Medical Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) Correctional Officer D.C. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) is marked of Bozier Minnick Amanda Knight 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is Clarence E. Williams/Grandson 13304 Burleigh St., Upper Marlboro, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 3-21-12 cemetery, crematory or other place) 0 1 Burial 2 Cremation 3 Removal from State injury 4 Donation 5 Other (Specify) Crematory.Inc. ## Beltsville.Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility. Henry S. Washington & Sons Co., Inc. CC0316 4925 Burroughs Ave. N.E. Washington D.C. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final TATAL Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examir burial-transi Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical death certificate be Box 68760 as IF FFMALE: use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown ō Month Year Pregnant at time of death Day ed by the at Unknown P.O. law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy To the Hospital or Attending Physician: The perform 1 Yes 2 No Yes 2 No Be (25. Was case referred to medical Division of Vital the funeral director. 26. Place of Death (Check only one) examiner? Hospital Other: 1 Yes 2 🔀 No ည 1 Inpatient 2 X ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending Accident
Suicide s after death. 1 Yes 2 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined within 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basic of examination and/or investigation in manner as stated. 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and∧i∮e of certifie completed cause of death (Item 23a) (Type, Print) 3001 ta 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State Registrar

Division of Vital To the within 2

Baltimore, Maryland 21215-0036

Box 68760

P.O. I

Records,

State

Medical

29a. Certifier

(Check

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Rate pu

ROINTAN FARAHIFAR

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

3.11.12

29c. License number

D43446

12150 Anapolis Road Soite 200 Glendle MD 20769

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2<u>012</u> Physician/ CLAIRE VIOLA MURPHY MARCH 14 8:10 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ST. MICHAELS 105 SEYMOUR AVENUE TALBOT 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days Hours Min Months 149-01-9004 NEW JERSEY 91 Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director MD TALBOT 1X Yes 2 ☐ No ST. MICHAELS 10e. Street and Number ö 10f, Zip Code 10g. Citizen of What Country? Funeral 23a105 SEYMOUR AVENUE 21663 USA items 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. ò 1 Never Married 2 Married Completed by Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", Specify: WHITE 3 ☑ Widowed 4 ☐ Divorced traumatic event, the Medical Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 JOHN GRAF MARY WOLFE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health au Important: If item 27 is any injury or other trau JAMES N. WALSH (SON) 23849 MT. MISERY ROAD, ST. MICHAELS, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION: 3/15/2012 STEVENSVILLE, MD Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, MERC SOUTH HARRISON STREET, EASTON, MD JOHN R. 21601 200 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final cardiomyopath Onset and Death Ischemic Pnysician/ disease or condition resulting in death) 109×5 Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physiciar Physician/Medical death certificate be Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No į 5 Other (specify) Month Day Year Pregnant at time of death ☐ Yes ∠ ☐
☐ Unknown been signed by the should be detached g Unknown Hospital or Attending Physician: The law requires that the c 24 hours after death.

Yuneral Director: After this certificate has been signed by the et affiled in by the funeral director, page 2 should be detached. P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 Yes 25. Was case referred to medical **Division of Vital** 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Statesidence 6 Other (Specify) Hospital: 2 X No 1 🗌 Yes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury 1 🖾 Natural 5 Pending work?
1 Yes 2 No 2 Accident Investigation 6 Could not be Suicide within 24 hours after de To the Funeral Directo completed filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

256

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

only one) 29b. Signature and title of certifie

> 2195 WASHINGTONST gistrar's Signature

29c. License number

S

29d. Date signed (Month, Day, Year) 15

EASTON

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Muller March Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Town, or Location of Death ltospital top Kins Morc 8. Date of Birth (Month, Day, Year) 7. Age (In yrs, last birthday) If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign Min. Hours **Director** 228-21-7089 1 M 2 X F 62 August 14, 1949 Argentina 28a-f show 10b. County 10c. City, Town or Location must be notified at 10d. Inside City Limits Director 1 Yes 2x No Virginia Fairfax 0akton o 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral ortant: If item 27 is marked other than "natural", or items 23a injury or other traumatic event, the Medical Examiner must b 10102 Bushman Drive 22124 U.S.A. 1 and 2 should be filed within 72 hours after death of Health and Mental Hygiene.
item 27 is marked other than "natural" or isomo 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. Completed by 1 Never Married 2 X Married Yes 2 No Baltimore, Maryland 21215-0036 1 X Yes 2 □ No Specify: Argentine If Yes, Give 3 🗆 Widowed 4 🗆 Divorced Specify: White Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business/Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Joaquin Galice Maria Teresa Aramburu 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Muller (Husband) 10102 Bushman Drive, Oakton, VA 22124 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or ot once, 20c. Location - City or Town, State Page 1 cemetery, crematory or other place;
National Funeral Home 1 🔲 Burial 2 🙀 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/15/12 Falls Church, Virginia 22. Name and Address of Facility Murphy Falls Church Funeral Home Montage 30 3 0 1102 W. Broad St., Falls Church, VA 22046 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician) Intracranial disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Metastatic Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence on. burial-transit requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Day Year 1 Yes 2 D the a Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of certificate has page 2 autopsy performed? death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Hospital or Attending Physician: Be 26. Place of Death (Check only one) examiner? Hospital 1 Tyes 2 No ည 1 XInpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier MA Res-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-201

State Registrar 600

N

tkbari

32. Registrar's Signature

ama

31. Date filed (Month, Day, Year)

St. Balkmare

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 4:15 PM Wayne W. Murphy 2012 March Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Caroline Denton 6192 Laurel Grove Road Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Maryland Months Days Hours (Month, Day, Year, 1 🔀 M 2 🗆 F 216-48-6159 64 **Director** 1947 Usual Residence of Decedent or 28a-f show notified at 10a. State 10d. Inside City Limits with the Maryland 10c. City, Town or Location Director Denton Caroline MD 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò ian "natural", or items 23a o Medical Examiner must be Funeral United States 21629 6192 Laurel Grove Road death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 D Married ģ within 72 hours after Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 🗆 Widowed 4 🗆 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry Caroline County Dept. life. DO NOT use retired) and Mental Hygiene.

is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) the Of Public Works Supervisor Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ew once. Melvin H. Murphy Gladys P. Wells 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Darleen R. Murphy/Spouse 6192 Laurel Grove Rd., Denton, MD 21629 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, Burial 2 Cremation 3 Removal from State Federalsburg, MD 03/16/12 Concord Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Framptom Funeral Home, P.A. Signature of Funeral Service Licensee 216 N. Main St., Federalsburg, MD 21632 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physicians/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami and I-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last burial physician sthe burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Year Month 5 Other (specify) Day Pregnant at time of death signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown cate has been sig page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 Nc certificate 1 Yes 2 No 25. Was case referred to medical Be director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA : After this c tuneral dir 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No I Director: A d in by the fi Accident Investigation 6 Could not be Suicide within 24 hours after de

To the Funeral Directo

completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

DHMH 17 Rev 7/2009

Registrar

State

only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Stevens

3683

Ertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

R111187

Choptank Rd, Preston, MD.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Marvin Ralph Marks 2012 March 11:20 a^M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 42762 St. John's Road Hollywood St. Mary's Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8 Date of Birth **Funeral** Min (Month, Day, Year) Hours **Director** 177-12-6779 1 M 2 🗆 F 90 Yrs. 12/28/1921 Usual Residence of Decedent Pennsylvania 28a-f show 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland 1 Yes 2X No St. Mary's Hollywood 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Examiner must be 23a Funeral 42762 St. John's Road 20636 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No Black, White, etc. ō þ 1 Never Married 2 X Married be filed within 72 hours after Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", Specify: Completed 3 Widowed 4 Divorced White event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working d Mental Hygiene. marked other than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Furniture Refinsher Furniture Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Ra1ph 0swin Marks Hattie Emma Stickler other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Rose Marks/Spouse 42762 St. John's Rd., Hollywood, MD 20636 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Mattingley Gardiner place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Leonardtown, MD Funeral Home, P.A. Crematory 03/16/2012 21. Signature of Funeral Service Liceus Mattingley-Gardiner Funeral Home, P.A. 41590 Fenwick St., Leonardtown, MD 20650 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ tothriv Medical resulting in death) Examiner Cequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Exami Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last burialng physician a Physician/Medical Chrebrovasculor disease Box 68760 attending p 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month the a g Unknown P.O. signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ marcion Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed neart to Were autopsy findings available prior to completion of cause of 24a. Was an autopsv perform death? atifal this certificate 1 ☐ Yes 2 ☐ No Yes 25. Was case refered to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 K Residence 6 Other (Specify) 2 No Hospital: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending after death

Director: A 1 🗌 Yes 2 🔲 No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined hin 24 hours aft the Funeral Di mpletely filled ir Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 within 2

To the F

complete Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signatu eand title of certifier 29c. License number 03/14/2012 D28544 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 06-2011

Colleen D. Jude, M.D.

MAR 19

31. Date filed (Month, Day, Year,

Registrar's Signatur

23348 Nicholson St., Hollywood, MD 20636

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Catherine Ann Mattingly 2012 1:48 A March Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Hospice House of St. Mary's Callaway Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 **Funeral** Months Hours 220-62-8647 Director 1 M 2 🔀 F 56 10/7/1955 Maryland Usual Residence of Decedent show 10d. Inside City Limits 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director 1 🗌 Yes 2 ื No **Maryland** Abe11 St. Mary's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20606 21468 Abell Road USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Completed by 1 Never Married 2 Married 2 XNo Baltimore, Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give Specify: White 3 - Widowed 4 - Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Mail Carrier **US Postal Service** 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ John William Quade Sr. Alice Marie Suite 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21468 Abell Road Abell, MD Ronald L. Mattingly/ Husband 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Sacred Heart 03/19/2012 Bushwood, MD 4 Donation 5 Other (Specify) Name and Address of Facility

Mattingley—Gardiner Funeral home, P

41590 Fenwick St., Leonardtown, MD Jure of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to for as a consequence of cause. Enter Underlying The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last and the burial-trar Due to (or as a consequence of) attending physician I for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE f yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Year Month Day Pregnant at time of death be detached the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 48 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 has 2 🗆 No certificate 1 Yes To the Hospital or Attending Physician: Hospice funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 X Other (Specify House 1 🗌 Yes 은 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred : After t Certificate: 5 \square Pending 1 Yes 2 No Accident Investigation Could not be after deatl filled in by the Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner On the best of experience and death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

DHMH 17 Rev 06-2011

Registrar

State

3 🗆

Karen Bauer, M.D.

MAR 19

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

D62042

28103 Three Notch Rd., Mechanicsville, MD 20659

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Alberta Dorothy 16, Morgan March 2012 9:20 P 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1820 Sollers Wharf Road Lusby Calvert 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Months Hours (Month, Day, Year) 220-46-5632 94 1 🗆 M 2 🕱 F Yrs. 02/02/1918 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No **Mechanicsville** Maryland St. Mary's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 40791 Morgan Brothers Road 20659 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married Yes 2 X No If Yes, Give Year or Dates 1 ☐ Yes 2 🛣 No Specify: Specify: 3 ₩ Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 10 <u>Homemaker</u> Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Fayette E. Fowler Virginia Lydia Stinnett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Teressa Quade/Daughter 23365 Hurry Road, Clements, MD 20624 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) All Faith Episcopal 3/20/2012 Mechanicsville, MD Name and Address of Facility
Mattingley-Gardiner Funeral Home, P.A.
41590 Fenwick St., Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition End Stage Conjestive Heart Failure 3 months resulting in death) Due to (or as a consequence of Myocardial Infarction 2 weeks Due to (or as a consequence of): 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ Month Day Year

Physician Medical Examiner

signed by the attending physician and

for use as the burial-tran

page 2 this certificate has

filled in by the funeral director,

completely

within 24 hours after deat To the Funeral Director;

Hospital

or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

Exami

Physician/Medical

2

mpleted

Medical

Physician/

Medical

Examiner

Funeral

Director

or 28a-f show notified at

ral", or items 23a or Examiner must be n

permit. Page 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hyglene. Important I filem 27 is marked other than "natural", or items 23a any hipty or other traumatic event, the Medical Examiner must 3b

Baltimore, Maryland 21215-0036

Director

Funeral

þ

Completed

Be

2

10a. State

Sequentially list conditions, if any, teauring to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe Yes 2 X 26. Place of Death (Check only one)

To Be Co	25. Was case referred examiner?	
Certificate:	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide	5 Pending Investigatio 6 Could not I

Hos	spital: 1 🗌 Inpatient 2 🗍	ER/Outpatier
n	28a. Date of injury (Month, Day, Year)	28b. Time of injury
е	00 DI 611 ALL	

/Outpatient	3 □	DOA	Other.	☐ Nursing H	ome	5 Residence	6 X Other (Specify Residen
b. Time of injury	М		Injury at work? 1 □ Yes			Describe how inj	
, farm, stree	t, facto	ry, of	fice		28f.	Location (Street a	and Number or Rural Route Number,

No	1 Yes	2 No
	D	auchtern
ce 6 X	Other (Specify	Residence
	occurred	

4 Homicio	de determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
9a. Certifier	1 Certifying Physic	ian: To the best of my knowledge, death occurred at the time, date and place

building, etc. (apechy)		City or Town, State)
Certifying Physician: To the best of my knowledge, de	ath occurred at the time, date and place, a	and due to the cause(s) and manner as stated.
3 Certifying Nurse Practitioner: To the best of my knowledge of the best of my knowledge.	nvestigation, in my opinion, death occurred at	at the time, date and place, and due to the cause(s) and manner state
	ago, acati occarios at the time, cate and pie	acc, and due to the cadocia, and marrier as states.

>	Wohnt 1	13	aves	my
9b. Signature	and title of certifier			

29c. License number DO014168 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 28103 Three Notch Rd., Mechanicsville, MD 20659

Robert J. Bauer, M.D.

31. Date filed (Month, Day, Year, MAR 2 2 2012

Registrar

State

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year 7:23 PM CHARLES RONALD MEADOWS 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Salisbury 4c. County of Death Examiner Hospice at the icomico Coastal 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Funeral Months Hours Min (Month, Day, Year) 236-60-8994 **Director** 1 **※**M 2 □ F 70 Yrs 8/6/1941 WEST VIRGINIA Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits notified at Director 28a-f 1 X Yes 2 No MARYLAND WORCESTER **BERLIN** 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? items 23a or ner must be n Funeral 21811 USA 133 NOTTINGHAM LANE 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian the Medical Examiner Armed Forces? Black, White, etc. Baltimore, Maryland 21215-0036 ō þ 1 Never Married 2 X Married filed within 72 hours after If Yes, Give Year or Dates 1 Yes 2 XNo Specify: Specify "natural", 3 Widowed 4 Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4 or 5+) MINING COAL MINER other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve ည EARNEST L. MEADOWS CLARICE JANE LOSH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 133 NOTTINGHAM LANE, BERLIN, MD 21811 NANCY MEADOWS / WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 X Removal from State cemetery, crematory or other place, 3/24/2012 PROSPERITY, WV 4 ☐ Donation 5 ☐ Other (Specify) BLUE RIDGE MEMORIAL GARDENS 21. Signature of Funeral 8 22. Name and Address of Facility NEWCOMB AND COLLINS FUNERAL HOME, P.A., 308 HIGH ST., CAMBRIDGE, MD 21613 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician CRREBROVAS CULL disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to lor as a consequence of pue use as the burial-trai Due to (or as a consequence of) attending physician for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Other (specify) Month Dav Year Pregnant at time of death ed by the a detached f Unknown been signed by to should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably Tunknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes No 24a Was an page 2 has autopsy within 24 hours after death.

To the Funeral Director: After this certificate ! director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence Hospital ဂ္ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 28b. Time of 28d. Describe how injury 28c. Injury at 5 Pending injury Natural work?
1 Yes 2 No ☐ Accident Investigation filled in by the 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🗲 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 06-2011

ricgistrai

1805

30. Name and address of person who completed gause of death (Item 23a) (Type, Print)

2. Reaistrar's Sign

(Month, Day, Year)
NAR 2 1 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ^D2012 March 12, 8:30 A M <u> William Andrew McFarland</u> Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Queen Anne's 325 Hemsley Drive Queenstown Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8 Date of Birth **Funeral** Hours (Month, Day, Year) 473-14-9987 96 **Director** 1**XX**M 2 □ F 11/19/1915 Wisconsin Usual Residence of Deceden 28a-f show at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Queen Anne's notified Queenstown 1 Yes 2 XNo 10e. Street and Number with the ō 10f. Zip Code 10g. Citizen of What Country? ms 23a or Funeral U.S.A. 325 Hemsley Drive 21658 items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2★★★ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Examiner ō þ 1 Never Married 2 Married 1 Yes 2 the Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 72 hours after Specify: White 1 Yes 2XXNo Specify: "natural" 3 XIXWidowed 4 □ Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Vulcan Materials Co. the permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygier Important: If item 27 is marked other tany injury or other traumatic event, the once. Chemist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harold Francis McFarland Alice Mary Trebilcock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alice Collins-daughter 325 Hemsley Drive, Queenstown, Md. 21658 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Huntt Crematory 20c. Location - City or Town, State 1 ☐ Burial ※XXCremation 3 ☐ Removal from State Waldorf, Maryland 3/16/2012 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Robert E. Evans Funeral Home 22. Name and Address of Facility 16000 Annapolis Road, Bowie, Maryland 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ HULMONARY EVER disease or condition resulting in death) Medical WE HEART FAILURE Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine requires that the death certificate be executed and -tran that initiated events resulting in death) Last burialphysician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: use 23b. Was decedent pregnant 23d, Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death 2 No Unknown 9 Unknown signed by d Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 18WE CARDUO VASCOXAR DISCA (E 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy perforr death? 1 Yes Yes 2 No 2 No 25. Was case referred to manical Be director 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 X No Other: မြ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) s after dea... ral Director: After u... 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d, Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 hound to the second 29a. Certifier (Check 3 Certifying Nurse Actitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one ho completed cause of death (Item 23a) (Type, Print) tem 23a) (Type, Print) 14300 GALLANT FOX LA#122 BOOV (E)

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ March 13, Day 2012 Year Nancy Catherine Miller 10:19 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death WMHS Regional Medical Center Cumberland Allegany Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Hours 214-42-0455 **Director** 1 🗆 M 2 🕱 F 68 April 16, 1943 Maryland 28a-f show 10c. City, Town or Location Examiner must be notified at 10a. State 10d. Inside City Limits Director MD Garrett Grantsville 1 🕱 Yes 2 🗌 No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Funeral 23a 184 Grant St., P.O. Box 41 21536 USA items hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc ò 1 Never Married 2 X Married þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Specify: White Completed 3 Widowed 4 Divorced the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working than, life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ and Mental Hygiene. Hospital Registered Nurse item 27 is marked other other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Elmer Miller Rosa Lewis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 41, Grantsville, MD C. Kent Miller/Husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of I Important: If its any injury or of Countrsy Side Crematory 2/15/12 1 Burial 2 X Cremation 3 Removal from State Davidsville, PA 4 ☐ Donation 5 ☐ Other (Specify) ure of Funeral Service Licensee 22. Name and Address of Facility Newman Funeral Homes, P.A. P.O. Box 275, Grantsville, MD 21536 23a. Part 1. Into the disease, a shock, or heart failure. List of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, st only one cause on each line. Approximate terval Between Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Exami burial-transi The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last physician Physician/Medical P.O. Box 68760 the IF FEMALE asn 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Cectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death be detached Unknowr Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Division of Vital Records, Completed 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy perform death? certificate Yes To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: 1 Tes 1 Inpatient 2 ER/Outpatient 3 XDOA 4 Nursing Home 5 Residence 6 Other (Specify, funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b, Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After X Natural 5 Pending 1 Yes 2 🗌 No filled in by the Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 KC certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated completely 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated MDD12829-2 allen

State Registrar 312 INDUSTRIAL PARK

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

THOMAS

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
Amend 23a per med cert. G926 4/12/12 dk
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Ī Month 3 0 М Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Mandrin Hospice House Anne Arundel Harwood Social Security Number Age (In yrs. last birthday) **Funeral** If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) Months Hours Min. 217-80-5698 82 Director 1 M 2 F 4/3/1929 France 28a-f show 10a. State 10b. County the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Annapolis Maryland Anne Arundel 1 Yes 2 X No ò 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 1926 Hidden Point Road 21409 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces Black. White, etc. ō þ 1 Never Married 2 K Married 1 Yes 2 No Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 K No Specify: "natural", 3 Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Renee Mathis Josephine Verpraet 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1926 Hidden Point Road, Annapolis, MD 21409 Department of Health ar Important: If item 27 is, any injury or att Marie-Elvire Magnani - Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

Baltimore Crematory 20c. Location - City or Town, State Date 1 ☐ Burial 2 🙀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/15/2012 Baltimore, MD Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St, Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ TWSUFFECTE RESP disease or condition resulting in death) TE Medical Due to (or as a consequence of) **Examiner** Aspiration Pneumonia weeks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): Cardiovascular Disease years and resulting in death) Last Due to (or as a consequence of) burial attending physician Physician/Medical as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregna 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 mop Month Day Year Pregnant at time of death 1 Yes 2 No 9 Unknown P.O. been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 Tes 2 No 3 Probably 4 Tunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas page 2 autopsy performed certificate 2 🔲 No Yes 25. Was case referred to medical of Vital Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Spec Hospital 은 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After Attending 1 Matural injury 5 Pending work?
1 Yes 2 No Division Accident Investigation after death n 24 hours after dea le Funeral Director nletely filled in by th Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital or Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 24 hor To the Fune completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one the 29b. Signature and title of certifie 0 29d. Date signed (Month, Day, Year) ddress of person who completed cause of death (Item 23a) (Type, Print) TAYLOR 31. Date filed (*Month, Day, Year*) **MAR 1 9 2012** Begistrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene fin 3/20/12 tt Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 14 Day R. Melvin James 2012 10:40 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PG Clinton Southern Maryland Hospital If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Numbe 7. Age (In vrs. last birthday 8. Date of Birth **Funeral** Months Days Hours Min (Month, Day, Year) 579-58-5750 Director 67 July 26,1944 DC Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director PGTemple Hills Yes 2 No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral US 20748 2303 Saint Clair Drive 12. Was Decedent Ever in U.S Armed Forces? within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Specify. 3 Widowed 4 Divorced Black Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ne any injury or other traumatic event the once." (Specify only highest grade completed) DC Government Elementary/Secondary (0-12) College (1-4 or 5+) Maintenance 10th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mary Brown Buddy Melvin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailin Raines AMT ROW The Or Rural Route Number, City or Town, State, Zip Code) 13775 Ballantree Lane, Waldorf, MD 20601 Leon Rutland/ Brother 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 3-16-2012 cemetery, crematory or other place) 1 ☐ Burial 2 🛱 Cremation 3 ☐ Aemoval from State Riverdale, MD Riverdale Park Crematory 4 ☐ Donation 5 ☐ Other (Specify) Pope Funeral Homes, P.A. 21. Sign were f Funeral Service Lice 22. Name and Address of Facility 5538 Marlboro Pike, Forestville, MD 20747 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Phyrician disease or condition resulting in death) Medical Due to (or as a consequer Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as Exami burial-transi Cause (Disease or injury that initiated events resulting in death) Last and attending physician Physician/Medical certificate be Box 68760 as the l IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery ŏ in the past 12 months? Year Month Day ate has been signed by the a page 2 should be detached 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ To the Hospital or Attending Physician: The law requires to within 24 hours after death.

To the Funeral Director: After this certificate has been sign. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

Yes 2 No 2 🔀 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 2 🖺 No Hospital 1 Tes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred Natural iniury 5 Pending Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier 1 [X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar DHMH 17 Rev 06-2011

State

29b. Signature and title of certifie

Date filed (Month, Day, Year)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2012 Physician/ March 10. 7:40 AM Mobley David Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Fort Washington Fort Washington Medical Center Social Security Number 6. Sex 1 **3** M 2 □ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours 05/09/1939 Washington, DC Yrs. Director 72 579-50-7197 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland ortant; If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No Maryland Prince Georges Fort Washington 10e. Street and Number 10g. Citizen of What Country? Funeral 20744 U.S.A. 201 Major King Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 X Divorced **Black** Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 10 Stock Clerk Giant Food and Drug Mental Hygier Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Mobley DC Jefferson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st.
Department of Health ar
Important: If item 27 is
any injury or other trau I1 60030 <u> Patricia Mobley-Dixon/daughter|1470 Lee Ward Ct. Grayslake.</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Crematory 03/20/2012 Brentwood, MD 21. Signature of Funeral Service Licens 22. Name and Address of Facility Fort LIncoln Funeral Home Ka. 3401 Bladensburg Rd. Brentwood, MD 20722 23a. Part J. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) COROMAN unknown Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 5 Other (specify) Pregnant at time of death Pregnant Unknown signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 tolknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an page 2 s autopsy performed? After this certificate 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 🔲 Yes 2 NO ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending in 24 hours after deau...
The Funeral Director: Aft Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar DHMH 17 Rev 7/2009

State

within 2 To the F

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Ugn

MD

MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

200055697

11711 Livingston Road

Fort Washington, MD 20744

29d, Date signed (Month, Day, Year)

2012